SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 2247

(SENATE AUTHORS: ABELER)

DATE	D-PG	OFFICIAL STATUS
03/11/2019		Introduction and first reading
		Referred to Human Services Reform Finance and Policy

A bill for an act

relating to human services; modifying policy provisions governing disability services; amending Minnesota Statutes 2018, sections 144A.471, subdivision 8; 144A.475, subdivision 6; 176.011, subdivision 9; 216C.435, subdivision 13; 245A.03, subdivision 7; 245C.03, subdivision 2; 245C.04, subdivision 3; 245C.10, subdivision 3; 245C.16, subdivision 1; 245D.03, subdivision 1; 245D.071, subdivisions 1, 3; 245D.09, subdivision 4a; 245D.091, subdivisions 2, 3, 4; 252.32, subdivisions 1a, 3a; 256B.038; 256B.04, subdivision 21; 256B.0621, subdivision 2; 256B.0625, by adding a subdivision; 256B.0651, subdivisions 1, 2, 12, 13; 256B.0652, subdivisions 2, 5, 8, 10, 12; 256B.0653, subdivision 3; 256B.0659, subdivision 3a; 256B.0705, subdivisions 1, 2; 256B.0711, subdivisions 1, 2; 256B.0911, subdivisions 1a, 3a, 3f, 6; 256B.0913, subdivision 5a; 256B.0915, subdivisions 3a, 6; 256B.0916, subdivision 9; 256B.0918, subdivision 2; 256B.092, subdivision 1b; 256B.093, subdivision 4; 256B.097, subdivision 1; 256B.439, subdivision 1; 256B.49, subdivisions 13, 14, 17; 256B.4914, subdivisions 2, 3, 14; 256B.501, subdivision 4a; 256B.69, subdivision 5a; 256B.765; 256B.85, subdivisions 1, 2, 4, 5, 6, 8, 9, 10, 11, 11b, 12, 12b, 13a, 18a, by adding a subdivision; 256D.44, subdivision 5; 256I.05, subdivision 1a; 256J.21, subdivision 2; 256J.45, subdivision 3; 394.307, subdivision 1; 462.3593, subdivision 1; 604A.33, subdivision 1; 609.232, subdivisions 3, 11; 626.556, subdivisions 2, 3, 3c, 4, 10d; 626.5572, subdivisions 6, 21; Laws 2017, First Special Session chapter 6, article 1, section 44; repealing Minnesota Statutes 2018, sections 256.476, subdivisions 1, 2, 3, 4, 5, 6, 8, 9, 10, 11; 256B.0625, subdivisions 19a, 19c; 256B.0652, subdivision 6; 256B.0659, subdivisions 1, 2, 3, 3a, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 11a, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31.

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

Section 1. Minnesota Statutes 2018, section 144A.471, subdivision 8, is amended to read:

Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise provided in this chapter, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

(b) An exemption under this subdivision does not excuse the exempted individual or organization from complying with applicable provisions of the home care bill of rights in section 144A.44. The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) an individual or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program ~~as authorized under sections 256B.0625, subdivision 19a, and 256B.0659~~;

(2) a provider that is licensed by the commissioner of human services to provide semi-independent living services for persons with developmental disabilities under section 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

(3) a provider that is licensed by the commissioner of human services to provide home and community-based services for persons with developmental disabilities under section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

(4) an individual or organization that provides only home management services, if the individual or organization is registered under section 144A.482; or

(5) an individual who is licensed in this state as a nurse, dietitian, social worker, occupational therapist, physical therapist, or speech-language pathologist who provides health care services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2018, section 144A.475, subdivision 6, is amended to read:

Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The owner and managerial officials of a home care provider whose Minnesota license has not been renewed or that has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted a home care license, including other licenses under this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services ~~under section 256B.0659~~ for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

(b) The commissioner shall not issue a license to a home care provider for five years following the effective date of license nonrenewal or revocation if the owner or managerial official, including any individual who was an owner or managerial official of another home care provider, had a Minnesota license that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of any home care provider that includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.

(d) The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of the notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well-being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials with the home care provider poses to client health, safety, and well-being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval

is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2018, section 176.011, subdivision 9, is amended to read:

Subd. 9. **Employee.** (a) "Employee" means any person who performs services for another for hire including the following:

(1) an alien;

(2) a minor;

(3) a sheriff, deputy sheriff, police officer, firefighter, county highway engineer, and peace officer while engaged in the enforcement of peace or in the pursuit or capture of a person charged with or suspected of crime;

(4) a person requested or commanded to aid an officer in arresting or retaking a person who has escaped from lawful custody, or in executing legal process, in which cases, for purposes of calculating compensation under this chapter, the daily wage of the person shall be the prevailing wage for similar services performed by paid employees;

(5) a county assessor;

(6) an elected or appointed official of the state, or of a county, city, town, school district, or governmental subdivision in the state. An officer of a political subdivision elected or appointed for a regular term of office, or to complete the unexpired portion of a regular term, shall be included only after the governing body of the political subdivision has adopted an ordinance or resolution to that effect;

(7) an executive officer of a corporation, except those executive officers excluded by section 176.041;

(8) a voluntary uncompensated worker, other than an inmate, rendering services in state institutions under the commissioners of human services and corrections similar to those of officers and employees of the institutions, and whose services have been accepted or contracted for by the commissioner of human services or corrections as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services in institutions where the services are performed by paid employees;

(9) a voluntary uncompensated worker engaged in emergency management as defined in section 12.03, subdivision 4, who is:

(i) registered with the state or any political subdivision of it, according to the procedures set forth in the state or political subdivision emergency operations plan; and

(ii) acting under the direction and control of, and within the scope of duties approved by, the state or political subdivision.

The daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed by paid employees;

(10) a voluntary uncompensated worker participating in a program established by a local social services agency. For purposes of this clause, "local social services agency" means any agency established under section 393.01. In the event of injury or death of the worker, the wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid in the county at the time of the injury or death for similar services performed by paid employees working a normal day and week;

(11) a voluntary uncompensated worker accepted by the commissioner of natural resources who is rendering services as a volunteer pursuant to section 84.089. The daily wage of the worker for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(12) a voluntary uncompensated worker in the building and construction industry who renders services for joint labor-management nonprofit community service projects. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(13) a member of the military forces, as defined in section 190.05, while in state active service, as defined in section 190.05, subdivision 5a. The daily wage of the member for the purpose of calculating compensation under this chapter shall be based on the member's usual earnings in civil life. If there is no evidence of previous occupation or earning, the trier of fact shall consider the member's earnings as a member of the military forces;

(14) a voluntary uncompensated worker, accepted by the director of the Minnesota Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily wage of the worker, for the purposes of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(15) a voluntary uncompensated worker, other than a student, who renders services at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the Blind, and whose services have been accepted or contracted for by the commissioner of education, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(16) a voluntary uncompensated worker, other than a resident of the veterans home, who renders services at a Minnesota veterans home, and whose services have been accepted or contracted for by the commissioner of veterans affairs, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(17) a worker performing services ~~under section 256B.0659~~ for a recipient in the home of the recipient or in the community ~~under section 256B.0625, subdivision 19a,~~ who is paid from government funds through a fiscal intermediary ~~under section 256B.0659, subdivision 33~~. For purposes of maintaining workers' compensation insurance, the employer of the worker is as designated in law by the commissioner of the Department of Human Services, notwithstanding any other law to the contrary;

(18) students enrolled in and regularly attending the Medical School of the University of Minnesota in the graduate school program or the postgraduate program. The students shall not be considered employees for any other purpose. In the event of the student's injury or death, the weekly wage of the student for the purpose of calculating compensation under this chapter, shall be the annualized educational stipend awarded to the student, divided by 52 weeks. The institution in which the student is enrolled shall be considered the "employer" for the limited purpose of determining responsibility for paying benefits under this chapter;

(19) a faculty member of the University of Minnesota employed for an academic year is also an employee for the period between that academic year and the succeeding academic year if:

(i) the member has a contract or reasonable assurance of a contract from the University of Minnesota for the succeeding academic year; and

(ii) the personal injury for which compensation is sought arises out of and in the course of activities related to the faculty member's employment by the University of Minnesota;

(20) a worker who performs volunteer ambulance driver or attendant services is an employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other entity for which the worker performs the services. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(21) a voluntary uncompensated worker, accepted by the commissioner of administration, rendering services as a volunteer at the Department of Administration. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(22) a voluntary uncompensated worker rendering service directly to the Pollution Control Agency. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees;

(23) a voluntary uncompensated worker while volunteering services as a first responder or as a member of a law enforcement assistance organization while acting under the supervision and authority of a political subdivision. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees;

(24) a voluntary uncompensated member of the civil air patrol rendering service on the request and under the authority of the state or any of its political subdivisions. The daily wage of the member for the purposes of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees; and

(25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in sections 145A.04 and 145A.06, responding at the request of or engaged in training conducted by the commissioner of health. The daily wage of the volunteer for the purposes of calculating compensation payable under this chapter is established in section 145A.06. A person who qualifies under this clause and who may also qualify under another clause of this subdivision shall receive benefits in accordance with this clause.

If it is difficult to determine the daily wage as provided in this subdivision, the trier of fact may determine the wage upon which the compensation is payable.

(b) For purposes of this chapter "employee" does not include farmers or members of their family who exchange work with other farmers in the same community.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2018, section 216C.435, subdivision 13, is amended to read:

Subd. 13. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482, or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section ~~256B.0625, subdivision 19a,~~ 256B.0651, 256B.0653, 256B.0654, ~~256B.0659,~~ or 256B.85;

(2) possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision;

(3) possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction that impairs the individual's ability to knowingly contract or otherwise protect the individual's own self-interest; or

(4) identifies as having dementia or Alzheimer's disease, or who exhibits behaviors that a reasonable person would suspect indicates the adult has Alzheimer's disease or other dementia.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

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

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

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of

reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

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

Sec. 6. Minnesota Statutes 2018, section 245C.03, subdivision 2, is amended to read:

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual required under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~ to have a background study completed under this chapter.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2018, section 245C.04, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 2, at least upon application for initial enrollment under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~.

(b) Organizations required to initiate background studies under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~ for individuals described in section 245C.03, subdivision 2, must submit a completed background study request to the commissioner using the electronic system known as NETStudy before those individuals begin a position allowing direct contact with persons served by the organization.

(c) Organizations required to initiate background studies under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~ for individuals described in section 245C.03, subdivision 2, must initiate a new background study through NETStudy when an individual returns to a position requiring a background study following an absence of 120 or more consecutive days.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2018, section 245C.10, subdivision 3, is amended to read:

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~ through a fee of no more than $20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2018, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside; and

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.556 or 626.557.

(d) This section does not apply to a background study related to an initial application for a child foster care license.

~~(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1.~~

~~(f)~~ (e) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

(1) intervention services, including:

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

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

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

(2) in-home support services, including:

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

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

(iii) semi-independent living services; and

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

(3) residential supports and services, including:

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

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

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

(4) day services, including:

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

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

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

Sec. 12. Minnesota Statutes 2018, section 245D.071, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2018, section 245D.09, subdivision 4a, is amended to read:

Subd. 4a. **Orientation to individual service recipient needs.** (a) Before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support, or any time the plans or procedures identified in paragraphs (b) to (f) are revised, the staff person must review and receive instruction on the requirements in paragraphs (b) to (f) as they relate to the staff person's job functions for that person.

(b) For community residential services, training and competency evaluations must include the following, if identified in the coordinated service and support plan:

(1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) ~~as defined under section 256B.0659, subdivision 1~~;

(2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet; and

(3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) ~~as defined under section 256B.0659, subdivision 1~~.

(c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.

(d) The staff person must review and receive instruction on medication setup, assistance, or administration procedures established for the person when assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may perform medication setup or medication administration only after successful completion of a medication setup or medication administration training, from a training curriculum developed by a registered nurse or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure unlicensed staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(1) specialized or intensive medical or nursing supervision; and

(2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life-threatening without proper use of the medical equipment, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness.

(g) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

(h) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to (10).

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

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

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

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

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

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

(11) demonstrated expertise with populations being served; and

(12) must be a:

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

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

inclusion, community alternative care, and developmental disability waiver plans or successor plans:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

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

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

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

(b) In addition, a behavior specialist must:

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

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

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

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

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

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

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

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

~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practices behavior support strategies as

well as behavior reduction approved intervention to the person who receives ~~behavioral~~ positive support; and

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

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

Sec. 17. Minnesota Statutes 2018, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of 21 and who have been certified disabled under section 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving: home and community-based waivered services for persons with disabilities authorized under section 256B.092 or 256B.49~~;~~ or personal care assistance under section 256B.0652~~; or a consumer support grant under section 256.476~~ are not eligible for support grants.

Families whose annual adjusted gross income is $60,000 or more are not eligible for support grants except in cases where extreme hardship is demonstrated. Beginning in state fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics Consumer Price Index (all urban) for that year.

(b) Support grants may be made available as monthly subsidy grants and lump-sum grants.

(c) Support grants may be issued in the form of cash, voucher, and direct county payment to a vendor.

(d) Applications for the support grant shall be made by the legal guardian to the county social service agency. The application shall specify the needs of the families, the form of the grant requested by the families, and the items and services to be reimbursed.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2018, section 252.32, subdivision 3a, is amended to read:

Subd. 3a. **Reports and allocations.** (a) The commissioner shall specify requirements for quarterly fiscal and annual program reports according to section 256.01, subdivision 2, paragraph (p). Program reports shall include data which will enable the commissioner to evaluate program effectiveness and to audit compliance. The commissioner shall reimburse county costs on a quarterly basis.

(b) The commissioner shall allocate state funds made available under this section to county social service agencies on a calendar year basis. The commissioner shall allocate to each county first in amounts equal to each county's guaranteed floor as described in clause (1), and second, any remaining funds will be allocated to county agencies to support children in their family homes.

(1) Each county's guaranteed floor shall be calculated as follows:

(i) 95 percent of the county's allocation received in the preceding calendar year;

(ii) when the amount of funds available for allocation is less than the amount available in the preceding year, each county's previous year allocation shall be reduced in proportion to the reduction in statewide funding, for the purpose of establishing the guaranteed floor.

(2) The commissioner shall regularly review the use of family support fund allocations by county. The commissioner may reallocate unexpended or unencumbered money at any time to those counties that have a demonstrated need for additional funding.

(c) County allocations under this section will be adjusted ~~for transfers that occur according to section 256.476 or~~ when the county of financial responsibility changes according to chapter 256G for eligible recipients.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2018, section 256B.038, is amended to read:

256B.038 PROVIDER RATE INCREASES AFTER JUNE 30, 1999.

(a) For fiscal years beginning on or after July 1, 1999, the commissioner of management and budget shall include an annual inflationary adjustment in payment rates for the services listed in paragraph (b) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. The adjustment shall be

accomplished by indexing the rates in effect for inflation based on the change in the Consumer Price Index-All Items (United States city average)(CPI-U) as forecasted by Data Resources, Inc., in the fourth quarter of the prior year for the calendar year during which the rate increase occurs.

(b) Within the limits of appropriations specifically for this purpose, the commissioner shall apply the rate increases in paragraph (a) to home and community-based waiver services for persons with developmental disabilities under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waivered services under community access for disability inclusion under section 256B.49; community alternative care waivered services under section 256B.49; brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services ~~under section 256B.0625, subdivision 19a~~; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 to 252.46; physical therapy services under section 256B.0625, subdivision 8; occupational therapy services under section 256B.0625, subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295; physician services under section 256B.0625, subdivision 3; dental services under section 256B.0625, subdivision 9; alternative care services under section 256B.0913; adult residential program grants under section 245.73; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; and semi-independent living services under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I.

(c) The commissioner shall increase prepaid medical assistance program capitation rates as appropriate to reflect the rate increases in this section.

(d) In implementing this section, the commissioner shall consider proposing a schedule to equalize rates paid by different programs for the same service.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure

to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000,

the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section ~~256B.0659 or~~ 256B.85.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2018, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. **Targeted case management; definitions.** For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~: skilled nursing visits, home health aide visits, home care nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with developmental disabilities;

(4) "relocation targeted case management" includes the provision of both county targeted case management and public or private vendor service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the lesser of:

(i) the last 180 consecutive days of an eligible recipient's institutional stay; or

(ii) the limits and conditions which apply to federal Medicaid funding for this service; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Community first services and supports.** Medical assistance covers community first services and supports as determined by section 256B.85.

Sec. 23. Minnesota Statutes 2018, section 256B.0651, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of sections 256B.0651 to 256B.0654 ~~and 256B.0659~~, the terms in paragraphs (b) to ~~(g)~~ (f) have the meanings given.

~~(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).~~

~~(c)~~ (b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person.

~~(d)~~ (c) "Home care services" means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; physical

therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy; home care nursing; and personal care assistance.

~~(e)~~ (d) "Home residence," effective January 1, 2010, means a residence owned or rented by the recipient either alone, with roommates of the recipient's choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient except as allowed under sections 256B.0652, subdivision 10, and 256B.0654, subdivision 4.

~~(f)~~ (e) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

~~(g)~~ (f) "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2018, section 256B.0651, subdivision 2, is amended to read:

Subd. 2. **Services covered.** Home care services covered under this section and sections 256B.0652 to 256B.0654 ~~and 256B.0659~~ include:

(1) nursing services under sections 256B.0625, subdivision 6a, and 256B.0653;

(2) home care nursing services under sections 256B.0625, subdivision 7, and 256B.0654;

(3) home health services under sections 256B.0625, subdivision 6a, and 256B.0653;

(4) personal care assistance services ~~under sections 256B.0625, subdivision 19a, and 256B.0659~~;

(5) supervision of personal care assistance services provided by a qualified professional ~~under sections 256B.0625, subdivision 19a, and 256B.0659~~;

(6) face-to-face assessments by county public health nurses for services ~~under sections 256B.0625, subdivision 19a, and 256B.0659~~; and

(7) service updates and review of temporary increases for personal care assistance services by the county public health nurse for services ~~under sections 256B.0625, subdivision 19a, and 256B.0659~~.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 25. Minnesota Statutes 2018, section 256B.0651, subdivision 12, is amended to read:

Subd. 12. **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision and ~~sections~~ section 256B.0652, subdivisions 3a, 4 to 11, 13, and 14, ~~and 256B.0659,~~ the cost-effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 26. Minnesota Statutes 2018, section 256B.0651, subdivision 13, is amended to read:

Subd. 13. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section and sections 256B.0653~~,~~ and 256B.0654~~, and 256B.0659~~. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 27. Minnesota Statutes 2018, section 256B.0652, subdivision 2, is amended to read:

Subd. 2. **Duties.** (a) The commissioner may contract with or employ necessary staff, or contract with qualified agencies, to provide home care authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The functions will be to:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a care plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost-effectiveness and nonduplication of medical assistance home care services;

(4) recommend the approval or denial of the use of medical assistance funds to pay for home care services;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner;

(6) conduct on-site assessments when determined necessary by the commissioner and recommend changes to care plans that will provide more efficient and appropriate home care; and

(7) on the department's website:

(i) provide a link to MinnesotaHelp.info for a list of enrolled home care agencies with the following information: main office address, contact information for the agency, counties in which services are provided, type of home care services provided, whether the personal care assistance choice option is offered, types of qualified professionals employed, number of personal care assistants employed, and data on staff turnover; and

(ii) post data on home care services including information from both fee-for-service and managed care plans on recipients as available.

(c) In addition, the commissioner or the commissioner's designee may:

(1) review care plans, service plans, and reimbursement data for utilization of services that exceed community-based standards for home care, inappropriate home care services, medical necessity, home care services that do not meet quality of care standards, or

unauthorized services and make appropriate referrals within the department or to other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

(3) coordinate home care services with other medical assistance services under section 256B.0625;

(4) assist the recipient with problems related to the provision of home care services;

(5) assure the quality of home care services; and

(6) assure that all liable third-party payers including, but not limited to, Medicare have been used prior to medical assistance for home care services.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a~~,~~ and 7~~, and 19a~~.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 28. Minnesota Statutes 2018, section 256B.0652, subdivision 5, is amended to read:

Subd. 5. **Authorization; home care nursing services.** (a) All home care nursing services shall be authorized by the commissioner or the commissioner's designee. Authorization for home care nursing services shall be based on medical necessity and cost-effectiveness when compared with alternative care options. The commissioner may authorize medically necessary home care nursing services in quarter-hour units when:

(1) the recipient requires more individual and continuous care than can be provided during a skilled nurse visit; or

(2) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

(b) The commissioner may authorize:

(1) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(2) home care nursing in combination with other home care services up to the total cost allowed under this subdivision and subdivision 7;

(3) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in clause (1) and, but for the provision of the nursing services, the recipient would require a hospital level of care as defined in Code of Federal Regulations, title 42, section 440.10.

(c) The commissioner may authorize up to 16 hours per day of medically necessary home care nursing services or up to 24 hours per day of medically necessary home care nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section and sections 256B.0651, and 256B.0653~~, and 256B.0659~~ than would otherwise be authorized under section 256B.49.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 29. Minnesota Statutes 2018, section 256B.0652, subdivision 8, is amended to read:

Subd. 8. **Authorization; time limits; amount and type.** ~~(a)~~ The commissioner or the commissioner's designee shall determine the time period for which an authorization shall be effective. If the recipient continues to require home care services beyond the duration of the authorization, the home care provider must request a new authorization. A personal care provider agency must request a new personal care assistance services assessment, or service update if allowed, at least 60 days prior to the end of the current authorization time period. The request for the assessment must be made on a form approved by the commissioner. An authorization must be valid for no more than 12 months.

~~(b) The amount and type of personal care assistance services authorized based upon the assessment and service plan must remain in effect for the recipient whether the recipient chooses a different provider or enrolls or disenrolls from a managed care plan under section~~

~~256B.0659, unless the service needs of the recipient change and new assessment is warranted under section 256B.0659, subdivision 3a.~~

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2018, section 256B.0652, subdivision 10, is amended to read:

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

(b) The commissioner may not authorize:

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

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

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

EFFECTIVE DATE. This section is effective the day following final enactment except the amendment to paragraph (b), clause (2), is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 31. Minnesota Statutes 2018, section 256B.0652, subdivision 12, is amended to read:

Subd. 12. **Assessment and authorization process for persons receiving personal care assistance and developmental disabilities services.** For purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and authorization process for persons receiving both home care and home and community-based waivered services for persons with developmental

disabilities shall meet the requirements of sections 256B.0651 to 256B.0654 ~~and 256B.0659~~ with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community-based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community-based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community-based waivered services for persons with developmental disabilities.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and authorization process will be held separate and distinct from the provision of services.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. Minnesota Statutes 2018, section 256B.0653, subdivision 3, is amended to read:

Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a certified home health aide using a written plan of care that is updated in compliance with Medicare regulations. A home health aide shall provide hands-on personal care, perform simple procedures as an extension of therapy or nursing services, and assist in instrumental activities of daily living ~~as defined in section 256B.0659~~, including assuring that the person gets to medical appointments if identified in the written plan of care. Home health aide

visits may be provided in the recipient's home or in the community where normal life activities take the recipient.

(b) All home health aide visits must have authorization under section 256B.0652. The commissioner shall limit home health aide visits to no more than one visit per day per recipient.

(c) Home health aides must be supervised by a registered nurse or an appropriate therapist when providing services that are an extension of therapy.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment required in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update

must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

Sec. 34. Minnesota Statutes 2018, section 256B.0705, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following ~~terms have~~ term has the ~~meanings~~ meaning given ~~them~~.

~~(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.~~

~~(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.~~

~~(d)~~ (b) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 35. Minnesota Statutes 2018, section 256B.0705, subdivision 2, is amended to read:

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must

occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement ~~under section 256B.0659, subdivision 14 or 19~~.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2018, section 256B.0711, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Commissioner" means the commissioner of human services unless otherwise indicated.

(b) "Covered program" means a program to provide direct support services funded in whole or in part by the state of Minnesota, including the Community First Services and Supports program; Consumer Directed Community Supports services and extended state plan personal care assistance services available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the Social Security Act, and Minnesota Statutes, including, but not limited to, sections 256B.0915, 256B.092, and 256B.49, and under the alternative care program, as offered pursuant to section 256B.0913; the personal care assistance choice program~~, as established pursuant to section 256B.0659, subdivisions 18 to 20~~; and any similar program that may provide similar services in the future.

(c) "Direct support services" means personal care assistance services covered by medical assistance ~~under section 256B.0625, subdivisions 19a and 19c~~; assistance with activities of daily living ~~as defined in section 256B.0659, subdivision 1, paragraph (b)~~, and instrumental activities of daily living ~~as defined in section 256B.0659, subdivision 1, paragraph (i)~~; and other similar, in-home, nonprofessional long-term services and supports provided to an elderly person or person with a disability by the person's employee or the employee of the person's representative to meet such person's daily living needs and ensure that such person may adequately function in the person's home and have safe access to the community.

(d) "Individual provider" means an individual selected by and working under the direction of a participant in a covered program, or a participant's representative, to provide direct

support services to the participant, but does not include an employee of a provider agency, subject to the agency's direction and control commensurate with agency employee status.

(e) "Participant" means a person who receives direct support services through a covered program.

(f) "Participant's representative" means a participant's legal guardian or an individual having the authority and responsibility to act on behalf of a participant with respect to the provision of direct support services through a covered program.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2018, section 256B.0711, subdivision 2, is amended to read:

Subd. 2. **Operation of covered programs.** All covered programs shall operate consistent with this section, including by affording participants and participants' representatives within the programs of the option of receiving services through individual providers as defined in subdivision 1, paragraph (d)~~, notwithstanding any inconsistent provision of section 256B.0659~~.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(ii) consumer support grants under section 256.476; or~~

~~(iii)~~ section 256B.85;

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective August 1, 2019, except the amendment striking section 256B.0625, subdivisions 19a and 19c, from paragraph (b), clause (1), item (i), is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

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

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

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

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the person has timely access to needed resources and must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota health care programs.

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

(g) The written community support plan must include:

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

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

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

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

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

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

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

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

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

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

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

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

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

Sec. 40. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and

opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments allow for a review of the current support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments verify continued eligibility or offer alternatives as warranted and provide an opportunity for quality assurance of service delivery. Face-to-face assessments must be conducted annually or as required by federal and state laws and rules. The certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and must complete the updated community support plan and the updated coordinated service and support plan no more than 60 calendar days from the reassessment visit.

Sec. 41. Minnesota Statutes 2018, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30, 2013, payment for long-term care consultation face-to-face assessment shall be made as described in this subdivision.

(b) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(c) The commissioner shall include the total annual payment determined under paragraph (b) for each nursing facility reimbursed under section 256B.431 or 256B.434 or chapter 256R.

(d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph (b). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(e) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services

while meeting the state's long-term care outcomes and objectives as defined in subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(f) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(g) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(h) Until the alternative payment methodology in paragraph (i) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(i) The commissioner shall develop an alternative payment methodology, effective on October 1, 2013, for long-term care consultation services that includes the funding available under this subdivision, and for assessments authorized under ~~sections~~ section 256B.092 ~~and 256B.0659~~. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal administrative reimbursement through federal financial participation funding, for all long-term care consultation activity. The alternative payment methodology shall include the use of the appropriate time studies and the state financing of nonfederal share as part of the state's medical assistance program. Between July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9 percent of the nonfederal share as reimbursement to the counties.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2018, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services,

assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. The lead agency must ensure that the benefit department recovery system in the Medicaid Management Information System (MMIS) has the necessary information on any other health insurance or third-party insurance policy to which the client may have access. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may authorize services to be provided by a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional ~~as defined in section 256B.0625, subdivision 19c~~. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

(d) Alternative care covers sign language interpreter services and spoken language interpreter services for recipients eligible for alternative care when the services are necessary to help deaf and hard-of-hearing recipients or recipients with limited English proficiency obtain covered services. Coverage for face-to-face spoken language interpreter services shall be provided only if the spoken language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph ~~(g)~~ (f), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services

for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

Sec. 44. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 45. Minnesota Statutes 2018, section 256B.0916, subdivision 9, is amended to read:

Subd. 9. **Legal representative participation exception.** The commissioner, in cooperation with representatives of counties, service providers, service recipients, family members, legal representatives and advocates, shall develop criteria to allow legal representatives to be reimbursed for providing specific support services to meet the person's needs when a plan which assures health and safety has been agreed upon and carried out by the legal representative, the person, and the county. Legal representatives providing support under the home and community-based waiver for persons with developmental disabilities ~~or the consumer support grant program pursuant to section 256.476,~~ shall not be considered to have a direct or indirect service provider interest under section 256B.092, subdivision 7, if a health and safety plan which meets the criteria established has been agreed upon and implemented. By August 1, 2001, the commissioner shall submit, for federal approval, amendments to allow legal representatives to provide support and receive reimbursement under the home and community-based waiver plan.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2018, section 256B.0918, subdivision 2, is amended to read:

Subd. 2. **Participating providers.** The commissioner shall publish a request for proposals in the State Register by August 15, 2005, specifying provider eligibility requirements, provider selection criteria, program specifics, funding mechanism, and methods of evaluation. The commissioner may publish additional requests for proposals in subsequent years. Providers who provide services funded through the following programs are eligible to apply to participate in the scholarship program: home and community-based waivered services for persons with developmental disabilities under section 256B.501; home and

community-based waivered services for the elderly under section 256B.0915; waivered services under community access for disability inclusion under section 256B.49; community alternative care waivered services under section 256B.49; brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services ~~under section 256B.0625, subdivision 19a~~; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 to 252.46; and intermediate care facilities for persons with developmental disabilities under section 256B.5012.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

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

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

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

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

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

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

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

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated service and support plan shall also specify other services the person needs that are not available;

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

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

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

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

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

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

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

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

Sec. 48. Minnesota Statutes 2018, section 256B.093, subdivision 4, is amended to read:

Subd. 4. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Traumatic brain injury" means a sudden insult or damage to the brain or its coverings, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, or physical functioning resulting in partial or total disability.

(b) "Home care services" means medical assistance home care services defined under section 256B.0625, subdivisions 6a~~,~~ and 7~~, and 19a~~.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 49. Minnesota Statutes 2018, section 256B.097, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

~~(4) consumer support grants under section 256.476;~~

~~(5)~~ (4) semi-independent living services under section 252.275; and

~~(6)~~ (5) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 50. Minnesota Statutes 2018, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement quality profiles for nursing facilities and, beginning not later than July 1, 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under sections 256B.0625, subdivisions 6a~~,~~ and 7~~, and 19a~~; 256B.0913; 256B.0915; 256B.092; 256B.49; and 256B.85, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The quality profiles must be developed using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The profiles must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The profiles must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions.

Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 51. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

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

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

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

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

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

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

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

(1) finalizing the coordinated service and support plan;

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

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

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of

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

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

(1) phasing out the use of prohibited procedures;

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

(3) accomplishment of identified outcomes.

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

Sec. 52. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

Sec. 53. Minnesota Statutes 2018, section 256B.49, subdivision 17, is amended to read:

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital. The commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:

(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or

(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.

(d) Beginning July 1, 2001, medically necessary home care nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0654 ~~and 256B.0659~~. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

(e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

(f) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

(g) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(h) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(i) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(j) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(k) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(l) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living ~~as defined under section 256B.0659, subdivision 1, paragraph (b)~~; instrumental activities of daily living ~~as defined under section 256B.0659, subdivision 1, paragraph (i)~~; ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support

plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

(m) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

(n) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 55. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

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

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

(18) supported employment services;

(19) supported living services;

(20) transportation services;

(21) individualized home supports;

(22) independent living skills specialist services;

(23) employment exploration services;

(24) employment development services;

(25) employment support services; and

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

Sec. 56. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

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

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

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

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

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

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

(d) Exception requests must include the following information:

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

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

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

(4) any contingencies for approval.

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

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

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

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

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

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

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

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

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

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

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

Sec. 57. Minnesota Statutes 2018, section 256B.501, subdivision 4a, is amended to read:

Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner shall adjust the limits of the established average daily reimbursement rates for waivered services to include the cost of home care services that may be provided to waivered services recipients. This adjustment must be used to maintain or increase services and shall not be used by county agencies for inflation increases for waivered services vendors. Home care services referenced in this section are those listed in section 256B.0651, subdivision 2. The average daily reimbursement rates established in accordance with the provisions of this subdivision apply only to the combined average, daily costs of waivered and home care services and do not change home care limitations under sections 256B.0651 to 256B.0654 ~~and 256B.0659~~. Waivered services recipients receiving home care as of June 30, 1992, shall not have the amount of their services reduced as a result of this section.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval

is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 58. Minnesota Statutes 2018, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

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

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

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

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

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

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as

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

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

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

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

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

so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

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

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

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

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

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

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

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the

form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 59. Minnesota Statutes 2018, section 256B.765, is amended to read:

256B.765 PROVIDER RATE INCREASES.

(a) Effective July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall provide an annual inflation adjustment for the providers listed in paragraph (c). The index for the inflation adjustment must be based on the change in the Employment Cost Index for Private Industry Workers - Total Compensation forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the fiscal year. The commissioner shall increase reimbursement or allocation rates by the percentage of this adjustment, and county boards shall adjust provider contracts as needed.

(b) The commissioner of management and budget shall include an annual inflationary adjustment in reimbursement rates for the providers listed in paragraph (c) using the inflation factor specified in paragraph (a) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

(c) The annual adjustment under paragraph (a) shall be provided for home and community-based waiver services for persons with developmental disabilities under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waivered services under community access for disability inclusion under section 256B.49; community alternative care waivered services under section 256B.49; brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services ~~under section 256B.0625, subdivision 19a~~; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 to 252.46; physical therapy services under section 256B.0625, subdivision 8; occupational therapy services under section 256B.0625,

subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295; alternative care services under section 256B.0913; adult residential program grants under section 245.73; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under section 252.275 including SILS funding under county social services grants formerly funded under chapter 256I; and community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 60. Minnesota Statutes 2018, section 256B.85, subdivision 1, is amended to read:

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

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

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

(d) ~~Upon federal approval,~~ CFSS ~~will~~ shall replace the personal care assistance program under sections ~~256.476, 256B.0625, subdivisions 19a and 19c,~~ 256B.0652, subdivisions 6 and 8, paragraph (b), and 256B.0659.

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

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 61. Minnesota Statutes 2018, section 256B.85, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency

must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

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

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in ~~section~~ sections 256B.0915, subdivision 6, and 256B.092, subdivision 1b.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 62. Minnesota Statutes 2018, section 256B.85, subdivision 4, is amended to read:

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

Sec. 63. Minnesota Statutes 2018, section 256B.85, subdivision 5, is amended to read:

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

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

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

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

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

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

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

Sec. 64. Minnesota Statutes 2018, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the coordinated service and support plan identified in ~~section~~ sections 256B.0915, subdivision 6, and 256B.092, subdivision 1b. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or FMS provider prior to starting

services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) include a plan for worker training and development provided according to subdivision 18a detailing what service components will be used, when the service components

will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

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

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

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

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

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

Sec. 65. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

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

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

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

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

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

(3) the presence of Level I behavior.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) an adjustment needed for administrative expenses.

Sec. 66. Minnesota Statutes 2018, section 256B.85, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(4) room and board costs for the participant;

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

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

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

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

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

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

(11) experimental treatments;

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

(13) membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the adult participant's health condition. The condition must be identified in the participant's CFSS service delivery plan and monitored by a Minnesota health care program enrolled physician;

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

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

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

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

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

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

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

(21) sterile procedures;

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

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

(24) home maintenance or chore services;

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

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

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

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

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

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

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

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

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

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

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

Sec. 67. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

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

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

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

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

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

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

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

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

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

(9) have an office located in Minnesota.

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

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

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

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

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

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

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

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

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

Sec. 68. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 69. Minnesota Statutes 2018, section 256B.85, subdivision 11b, is amended to read:

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

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

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

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

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

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

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

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

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

(1) the support worker begins providing services;

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

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

Sec. 70. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

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

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

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

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

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

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

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

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

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

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

(c) All CFSS agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS agency-provider do not need to repeat the required training if

they are hired by another agency, if they have completed the training within the past three years. CFSS agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency.

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

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

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

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

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

Sec. 71. Minnesota Statutes 2018, section 256B.85, subdivision 12b, is amended to read:

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

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

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

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

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

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

Sec. 72. Minnesota Statutes 2018, section 256B.85, subdivision 13a, is amended to read:

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

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

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

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

(2) data recording and reporting of participant spending;

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

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

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

(e) The FMS provider shall:

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

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

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

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

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

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

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

(f) The commissioner of human services shall:

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

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

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

Sec. 73. Minnesota Statutes 2018, section 256B.85, is amended by adding a subdivision to read:

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

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

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

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

(b) A participant's representative must:

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

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

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

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

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

(1) support worker;

(2) worker training and development service provider;

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

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

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

(6) FMS owner or manager; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the participant revokes the designation;

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

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

(4) the participant's representative is disqualified.

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

Sec. 74. Minnesota Statutes 2018, section 256B.85, subdivision 18a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 75. Minnesota Statutes 2018, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a setting authorized to receive housing support payments under chapter 256I.

(b) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician, advanced practice registered nurse, or physician assistant. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty

food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(e) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(f) A fee of ten percent of the recipient's gross income or $25, whichever is less, is allowed for representative payee services provided by an agency that meets the requirements

under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum federal Supplemental Security Income payment amount for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as in need of housing assistance and are:

(i) relocating from an institution, a setting authorized to receive housing support under chapter 256I, or an adult mental health residential treatment program under section 256B.0622;

(ii) eligible for personal care assistance ~~under section 256B.0659~~; or

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Housing assistance" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered in need of housing assistance for purposes of this paragraph.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 76. Minnesota Statutes 2018, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the county agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered

by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the Social Security Act; or funding from the medical assistance program ~~under section 256B.0659~~, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services ~~under section 256B.0659~~, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the county or counties in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to county human service agencies for beds permanently removed from the housing support census under a plan submitted by the county agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) Counties must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 77. Minnesota Statutes 2018, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for children under section 260C.4411 or chapter 256N, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through

public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

(12) payments by a vocational rehabilitation program administered by the state under chapter 268A, except those payments that are for current living expenses;

(13) in-kind income, including any payments directly made by a third party to a provider of goods and services;

(14) assistance payments to correct underpayments, but only for the month in which the payment is received;

(15) payments for short-term emergency needs under section 256J.626, subdivision 2;

(16) funeral and cemetery payments as provided by section 256.935;

(17) nonrecurring cash gifts of $30 or less, not exceeding $30 per participant in a calendar month;

(18) any form of energy assistance payment made through Public Law 97-35, Low-Income Home Energy Assistance Act of 1981, payments made directly to energy providers by other public and private agencies, and any form of credit or rebate payment issued by energy providers;

(19) Supplemental Security Income (SSI), including retroactive SSI payments and other income of an SSI recipient;

(20) Minnesota supplemental aid, including retroactive payments;

(21) proceeds from the sale of real or personal property;

(22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota permanency demonstration title IV-E waiver payments;

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities~~, consumer support grant funds under section 256.476,~~ and resources and services for a disabled household member under one of the home and community-based waiver services programs under chapter 256B;

(24) interest payments and dividends from property that is not excluded from and that does not exceed the asset limit;

(25) rent rebates;

(26) income earned by a minor caregiver, minor child through age 6, or a minor child who is at least a half-time student in an approved elementary or secondary education program;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash;

(46) the principal portion of a contract for deed payment;

(47) cash payments to individuals enrolled for full-time service as a volunteer under AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps National, and AmeriCorps NCCC;

(48) housing assistance grants under section 256J.35, paragraph (a); and

(49) child support payments of up to $100 for an assistance unit with one child and up to $200 for an assistance unit with two or more children.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 78. Minnesota Statutes 2018, section 256J.45, subdivision 3, is amended to read:

Subd. 3. **Good cause exemptions for not attending orientation.** (a) The county agency shall not impose the sanction under section 256J.46 if it determines that the participant has good cause for failing to attend orientation. Good cause exists when:

(1) appropriate child care is not available;

(2) the participant is ill or injured;

(3) a family member is ill and needs care by the participant that prevents the participant from attending orientation. For a caregiver with a child or adult in the household who meets the disability or medical criteria for home care services ~~under section 256B.0659~~, or a home and community-based waiver services program under chapter 256B, or meets the criteria for severe emotional disturbance under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when an interruption in the provision of those services occurs which prevents the participant from attending orientation;

(4) the caregiver is unable to secure necessary transportation;

(5) the caregiver is in an emergency situation that prevents orientation attendance;

(6) the orientation conflicts with the caregiver's work, training, or school schedule; or

(7) the caregiver documents other verifiable impediments to orientation attendance beyond the caregiver's control.

(b) Counties must work with clients to provide child care and transportation necessary to ensure a caregiver has every opportunity to attend orientation.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 79. Minnesota Statutes 2018, section 394.307, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Caregiver" means an individual 18 years of age or older who:

(1) provides care for a mentally or physically impaired person; and

(2) is a relative, legal guardian, or health care agent of the mentally or physically impaired person for whom the individual is caring.

~~(c) "Instrumental activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (i).~~

~~(d)~~ (c) "Mentally or physically impaired person" means a person who is a resident of this state and who requires assistance with two or more instrumental activities of daily living

as certified in writing by a physician, a physician assistant, or an advanced practice registered nurse licensed to practice in this state.

~~(e)~~ (d) "Relative" means a spouse, parent, grandparent, child, grandchild, sibling, uncle, aunt, nephew, or niece of the mentally or physically impaired person. Relative includes half, step, and in-law relationships.

~~(f)~~ (e) "Temporary family health care dwelling" means a mobile residential dwelling providing an environment facilitating a caregiver's provision of care for a mentally or physically impaired person that meets the requirements of subdivision 2.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 80. Minnesota Statutes 2018, section 462.3593, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Caregiver" means an individual 18 years of age or older who:

(1) provides care for a mentally or physically impaired person; and

(2) is a relative, legal guardian, or health care agent of the mentally or physically impaired person for whom the individual is caring.

~~(c) "Instrumental activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (i).~~

~~(d)~~ (c) "Mentally or physically impaired person" means a person who is a resident of this state and who requires assistance with two or more instrumental activities of daily living as certified in writing by a physician, a physician assistant, or an advanced practice registered nurse licensed to practice in this state.

~~(e)~~ (d) "Relative" means a spouse, parent, grandparent, child, grandchild, sibling, uncle, aunt, nephew, or niece of the mentally or physically impaired person. Relative includes half, step, and in-law relationships.

~~(f)~~ (e) "Temporary family health care dwelling" means a mobile residential dwelling providing an environment facilitating a caregiver's provision of care for a mentally or physically impaired person that meets the requirements of subdivision 2.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 81. Minnesota Statutes 2018, section 604A.33, subdivision 1, is amended to read:

Subdivision 1. **Application.** This section applies to residential treatment programs for children or group homes for children licensed under chapter 245A, residential services and programs for juveniles licensed under section 241.021, providers licensed pursuant to sections 144A.01 to 144A.33 or sections 144A.43 to 144A.47, personal care provider organizations ~~under section 256B.0659~~, providers of day training and habilitation services under sections 252.41 to 252.46, board and lodging facilities licensed under chapter 157, intermediate care facilities for persons with developmental disabilities, and other facilities licensed to provide residential services to persons with developmental disabilities.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 82. Minnesota Statutes 2018, section 609.232, subdivision 3, is amended to read:

Subd. 3. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a home care provider licensed or required to be licensed under sections 144A.43 to 144A.482; a residential or nonresidential facility required to be licensed to serve adults under sections 245A.01 to 245A.16; or a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections ~~256B.0625, subdivision 19a,~~ 256B.0651, 256B.0653, and 256B.0654.

(b) For home care providers and personal care attendants, the term "facility" refers to the provider or person or organization that exclusively offers, provides, or arranges for personal care services, and does not refer to the client's home or other location at which services are rendered.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval

is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 83. Minnesota Statutes 2018, section 609.232, subdivision 11, is amended to read:

Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections ~~256B.0625, subdivision 19a,~~ 256B.0651 to 256B.0654~~, and 256B.0659~~; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 84. Minnesota Statutes 2018, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(b) "Commissioner" means the commissioner of human services.

(c) "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H, 245D, or 245H;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization ~~as defined in section 256B.0625, subdivision 19a~~.

(d) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege sexual abuse or substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(e) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve sexual abuse or substantial child endangerment, and for reports of maltreatment in facilities required to be licensed or certified under chapter 245A, 245D, or 245H; under sections 144.50 to 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E; or in a nonlicensed personal care provider association ~~as defined in section 256B.0625, subdivision 19a~~.

(f) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to

function within a normal range of performance and behavior with due regard to the child's culture.

(g) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(h) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

(i) "Operator" means an operator or agency as defined in section 245A.02.

(j) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having

either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(k) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) striking a child who is at least age one but under age four on the face or head, which results in an injury;

(9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(10) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(11) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Report" means any communication received by the local welfare agency, police department, county sheriff, or agency responsible for child protection pursuant to this section that describes neglect or physical or sexual abuse of a child and contains sufficient content to identify the child and any person believed to be responsible for the neglect or abuse, if known.

(n) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports of known or suspected child sex trafficking involving a child who is identified as a victim of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321, subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(o) "Substantial child endangerment" means a person responsible for a child's care, by act or omission, commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) abandonment under section 260C.301, subdivision 2;

(3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(5) manslaughter in the first or second degree under section 609.20 or 609.205;

(6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(7) solicitation, inducement, and promotion of prostitution under section 609.322;

(8) criminal sexual conduct under sections 609.342 to 609.3451;

(9) solicitation of children to engage in sexual conduct under section 609.352;

(10) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(11) use of a minor in sexual performance under section 617.246; or

(12) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.503, subdivision 2.

(p) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (j), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (q) from the Department of Human Services.

(q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (p), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due

to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(r) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 85. Minnesota Statutes 2018, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, tribal social services agency, or tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H, 245D, or 245H; or a nonlicensed personal care provider organization ~~as defined in section 256B.0625, subdivision 19a~~. A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Notification requirements under subdivision 10 apply to all reports received under this section.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 86. Minnesota Statutes 2018, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization ~~under section 256B.0659~~. Copies of findings related to personal care provider organizations ~~under section 256B.0659~~ must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A, 245D, and 245H, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 87. Minnesota Statutes 2018, section 626.556, subdivision 4, is amended to read:

Subd. 4. **Immunity from liability.** (a) The following persons are immune from any civil or criminal liability that otherwise might result from their actions, if they are acting in good faith:

(1) any person making a voluntary or mandated report under subdivision 3 or under section 626.5561 or assisting in an assessment under this section or under section 626.5561;

(2) any person with responsibility for performing duties under this section or supervisor employed by a local welfare agency, the commissioner of an agency responsible for operating or supervising a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 245B or 245H; or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization ~~as defined in section 256B.0625, subdivision 19a,~~ complying with subdivision 10d; and

(3) any public or private school, facility as defined in subdivision 2, or the employee of any public or private school or facility who permits access by a local welfare agency, the Department of Education, or a local law enforcement agency and assists in an investigation or assessment pursuant to subdivision 10 or under section 626.5561.

(b) A person who is a supervisor or person with responsibility for performing duties under this section employed by a local welfare agency, the commissioner of human services, or the commissioner of education complying with subdivisions 10 and 11 or section 626.5561

or any related rule or provision of law is immune from any civil or criminal liability that might otherwise result from the person's actions, if the person is (1) acting in good faith and exercising due care, or (2) acting in good faith and following the information collection procedures established under subdivision 10, paragraphs (h), (i), and (j).

(c) This subdivision does not provide immunity to any person for failure to make a required report or for committing neglect, physical abuse, or sexual abuse of a child.

(d) If a person who makes a voluntary or mandatory report under subdivision 3 prevails in a civil action from which the person has been granted immunity under this subdivision, the court may award the person attorney fees and costs.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 88. Minnesota Statutes 2018, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed or certified according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H, 245D, or 245H, or a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal care provider organization ~~as defined in section 256B.0625, subdivision 19a~~, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency

knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 89. Minnesota Statutes 2018, section 626.5572, subdivision 6, is amended to read:

Subd. 6. **Facility.** (a) "Facility" means a hospital or other entity required to be licensed under sections 144.50 to 144.58; a nursing home required to be licensed to serve adults under section 144A.02; a facility or service required to be licensed under chapter 245A; a home care provider licensed or required to be licensed under sections 144A.43 to 144A.482; a hospice provider licensed under sections 144A.75 to 144A.755; or a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections ~~256B.0625, subdivision 19a,~~ 256B.0651 to 256B.0654~~, 256B.0659,~~ or 256B.85.

(b) For services identified in paragraph (a) that are provided in the vulnerable adult's own home or in another unlicensed location, the term "facility" refers to the provider, person, or organization that offers, provides, or arranges for personal care services, and does not refer to the vulnerable adult's home or other location at which services are rendered.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 90. Minnesota Statutes 2018, section 626.5572, subdivision 21, is amended to read:

Subd. 21. **Vulnerable adult.** (a) "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident or inpatient of a facility;

(2) receives services required to be licensed under chapter 245A, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is served in the Minnesota sex offender program on a court-hold order for commitment, or is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under sections 144A.43 to 144A.482; or from a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under section ~~256B.0625, subdivision 19a,~~ 256B.0651, 256B.0653, 256B.0654, ~~256B.0659,~~ or 256B.85; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

(b) For purposes of this subdivision, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 91. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to read:

Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to expand the exception to the consumer-directed community supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants who have a coordinated service and support plan which identifies the need for an increased amount of services or supports under consumer-directed community supports than the amount they are currently receiving under the consumer-directed community supports budget methodology:

(i) to increase the amount of time a person works or otherwise improves employment opportunities;

(ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes, section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or~~ paragraph (g), clause (1), item (iii); or

(iii) to develop and implement a positive behavior support plan; or

(2) home and community-based waiver participants who are currently using licensed providers for (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet the goals identified in paragraph (a), clause (1), items (i), (ii), and (iii).

(b) The exception under paragraph (a), clause (1), is limited to those persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for the goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to those persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

Sec. 92. **DIRECTION TO COMMISSIONER; NOTICE.**

The commissioner of human services shall publish on the Department of Human Services website notice of implementation at least 30 days before section 60 becomes effective.

Sec. 93. **DIRECTION TO COMMISSIONER; PCA TRANSITION TO CFSS.**

Upon the implementation of section 60, the commissioner of human services shall transfer an individual from personal care assistance services to community first services and supports after the individual's reassessment. Nothing in this article prohibits a provider from billing for personal care services according to Minnesota Statutes, chapter 256B, for one year from the date of the provision of service.

Sec. 94. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "developmental disability waiver" or similar terms to "developmental disabilities waiver" or similar terms wherever they appear in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

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

Sec. 95. **REPEALER.**

Minnesota Statutes 2018, sections 256.476, subdivisions 1, 2, 3, 4, 5, 6, 8, 9, 10, and 11; 256B.0625, subdivisions 19a and 19c; 256B.0652, subdivision 6; and 256B.0659, subdivisions 1, 2, 3, 3a, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 11a, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, are repealed.

EFFECTIVE DATE. This section is effective as determined by the commissioner of human services following federal approval but not more than two years after federal approval is obtained. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

256.476 CONSUMER SUPPORT PROGRAM.

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. The program shall:

(1) make support grants available to individuals or families as an effective alternative to the family support program, personal care attendant services, home health aide services, and home care nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person, the person's legal representative, or other authorized representative after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person, the person's legal representative, or other authorized representative. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the Department of Health or Human Services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving personal care attendant and home health aide services, or home care nursing under section 256B.0625; a family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) Individuals receiving home and community-based waivers under United States Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person, a person's legal representative, or other authorized representative will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person, a person's legal representative, or other authorized

representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any. The application shall be made to the local agency and shall specify the needs of the person or the person's legal representative or other authorized representative, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or the person's legal representative or other authorized representative, the local agency shall make grants to the person or the person's legal representative or other authorized representative. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's legal representative or other authorized representative.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.035.

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the family support program and personal care assistance services, home health aide services, or home care nursing services, the amount of funds transferred by the commissioner between the family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the monthly grant levels allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the monthly grant levels associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each person or the person's legal representative or other authorized representative cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Subd. 6. **Right to appeal.** Notice, appeal, and hearing procedures shall be conducted in accordance with section 256.045. The denial, suspension, or termination of services under this program may be appealed by a recipient or applicant under section 256.045, subdivision 3. It is an absolute defense to an appeal under this section, if the county board proves that it followed the established written procedures and criteria and determined that the grant could not be provided within the county board's allocation of money for consumer support grants.

Subd. 8. **Commissioner responsibilities.** The commissioner shall:

(1) transfer and allocate funds pursuant to subdivision 11;

(2) determine allocations based on projected and actual local agency use;

(3) monitor and oversee overall program spending;

(4) evaluate the effectiveness of the program;

(5) provide training and technical assistance for local agencies and consumers to help identify potential applicants to the program; and

(6) develop guidelines for local agency program administration and consumer information.

Subd. 9. **County board responsibilities.** County boards receiving funds under this section shall:

(1) determine the needs of persons and families for services and supports;

(2) determine the eligibility for persons proposed for program participation;

(3) approve items and services to be reimbursed and inform families of their determination;

(4) issue support grants directly to or on behalf of persons;

(5) submit quarterly financial reports and an annual program report to the commissioner;

(6) coordinate services and supports with other programs offered or made available to persons or their families; and

(7) provide assistance to persons or their families in securing or maintaining supports, as needed.

Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, a person's legal representative, or other authorized representative that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; and

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

Subd. 11. **Consumer support grant program after July 1, 2001.** Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651, 256B.0653, and 256B.0654, the maximum allowable monthly grant levels are calculated by:

(i) determining the service authorization for each individual based on the individual's home care assessment;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to 50 percent of the service authorization level of each home care rating; and

(iv) adjusting the result for any authorized rate changes provided by the legislature.

(2) The commissioner shall ensure the methodology is consistent with the home care programs.

256B.0625 COVERED SERVICES.

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0654. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0654, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

256B.0652 AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in subdivision 11 and section 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for recipients with dependencies in two or more activities of daily living:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) presence of complex health-related needs as defined in section 256B.0659; and

(3) presence of Level I behavior as defined in section 256B.0659.

(c) For purposes meeting the criteria in paragraph (b), the methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659, subdivision 4, paragraph (d).

(d) Effective July 1, 2011, the home care rating for recipients who have a dependency in one activity of daily living or Level I behavior shall equal no more than two units per day. Recipients with this home care rating are not subject to the methodology in paragraph (c) and are not eligible for more than two units per day.

(e) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

256B.0659 PERSONAL CARE ASSISTANCE PROGRAM.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under

sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

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

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

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

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

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

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

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

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

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

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

(c) Health-related procedures and tasks include the following covered services:

(1) range of motion and passive exercise to maintain a recipient's strength and muscle functioning;

(2) assistance with self-administered medication as defined by this section, including reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Subd. 3. **Noncovered personal care assistance services.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; or

(4) without authorization by the commissioner or the commissioner's designee.

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

(2) injections of fluids and medications into veins, muscles, or skin;

(3) home maintenance or chore services;

(4) homemaker services not an integral part of assessed personal care assistance services needed by a recipient;

(5) application of restraints or implementation of procedures under section 245.825;

(6) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor; and

(7) assessments for personal care assistance services by personal care assistance provider agencies or by independently enrolled registered nurses.

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

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

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician, specified in a personal care assistance care plan or community support plan developed under section 256B.0911, and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

(d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

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

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

Subd. 5. **Service, support planning, and referral.** (a) The assessor, with the recipient or responsible party, shall review the assessment information and determine referrals for other payers, services, and community supports as appropriate.

(b) The recipient must be referred for evaluation, services, or supports that are appropriate to help meet the recipient's needs including, but not limited to, the following circumstances:

(1) when there is another payer who is responsible to provide the service to meet the recipient's needs;

(2) when the recipient qualifies for assistance due to mental illness or behaviors under this section, a referral for a mental health diagnostic and functional assessment must be completed, or referral must be made for other specific mental health services or other community services;

(3) when the recipient is eligible for medical assistance and meets medical assistance eligibility for a home health aide or skilled nurse visit;

(4) when the recipient would benefit from an evaluation for another service; and

(5) when there is a more appropriate service to meet the assessed needs.

(c) The reimbursement rates for public health nurse visits that relate to the provision of personal care assistance services under this section and section 256B.0625, subdivision 19a, are:

(1) $210.50 for a face-to-face assessment visit;

(2) $105.25 for each service update; and

(3) $105.25 for each request for a temporary service increase.

(d) The rates specified in paragraph (c) must be adjusted to reflect provider rate increases for personal care assistance services that are approved by the legislature for the fiscal year ending June 30, 2000, and subsequent fiscal years. Any requirements applied by the legislature to provider rate increases for personal care assistance services also apply to adjustments under this paragraph.

(e) Effective July 1, 2008, the payment rate for an assessment under this section and section 256B.0651 shall be reduced by 25 percent when the assessment is not completed on time and the service agreement documentation is not submitted in time to continue services. The commissioner shall reduce the amount of the claim for those assessments that are not submitted on time.

Subd. 6. **Service plan.** The service plan must be completed by the assessor with the recipient and responsible party on a form determined by the commissioner and include a summary of the assessment with a description of the need, authorized amount, and expected outcomes and goals of personal care assistance services. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within ten working days of the assessment. The recipient or responsible party must be given information by the assessor about the options in the personal care assistance program to allow for review and decision making.

Subd. 7. **Personal care assistance care plan.** (a) Each recipient must have a current personal care assistance care plan based on the service plan in subdivision 6 that is developed by the qualified professional with the recipient and responsible party. A copy of the most current personal care assistance care plan is required to be in the recipient's home and in the recipient's file at the provider agency.

(b) The personal care assistance care plan must have the following components:

(1) start and end date of the care plan;

(2) recipient demographic information, including name and telephone number;

(3) emergency numbers, procedures, and a description of measures to address identified safety and vulnerability issues, including a backup staffing plan;

(4) name of responsible party and instructions for contact;

(5) description of the recipient's individualized needs for assistance with activities of daily living, instrumental activities of daily living, health-related tasks, and behaviors; and

(6) dated signatures of recipient or responsible party and qualified professional.

(c) The personal care assistance care plan must have instructions and comments about the recipient's needs for assistance and any special instructions or procedures required, including whether or not the recipient has requested a personal care assistant of the same gender. The month-to-month plan for the use of personal care assistance services is part of the personal care assistance care plan. The personal care assistance care plan must be completed within the first week after start of services with a personal care provider agency and must be updated as needed when there is a change in need for personal care assistance services. A new personal care assistance care plan is required annually at the time of the reassessment.

Subd. 7a. **Special instructions; gender.** If a recipient requests a personal care assistant of the same gender as the recipient, the personal care assistance agency must make a reasonable effort to fulfill the request.

Subd. 8. **Communication with recipient's physician.** The personal care assistance program requires communication with the recipient's physician about a recipient's assessed needs for personal care assistance services. The commissioner shall work with the state medical director to develop options for communication with the recipient's physician.

Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(b) A responsible party must be 18 years of age, actively participate in planning and directing of personal care assistance services, and attend all assessments for the recipient.

(c) A responsible party must not be the:

(1) personal care assistant;

(2) qualified professional;

(3) home care provider agency owner or manager;

(4) home care provider agency staff unless staff who are not listed in clauses (1) to (3) are related to the recipient by blood, marriage, or adoption; or

(5) county staff acting as part of employment.

(d) A licensed family foster parent who lives with the recipient may be the responsible party as long as the family foster parent meets the other responsible party requirements.

(e) A responsible party is required when:

(1) the person is a minor according to section 524.5-102, subdivision 10;

(2) the person is an incapacitated adult according to section 524.5-102, subdivision 6, resulting in a court-appointed guardian; or

(3) the assessment according to subdivision 3a determines that the recipient is in need of a responsible party to direct the recipient's care.

(f) There may be two persons designated as the responsible party for reasons such as divided households and court-ordered custodies. Each person named as responsible party must meet the program criteria and responsibilities.

(g) The recipient or the recipient's legal representative shall appoint a responsible party if necessary to direct and supervise the care provided to the recipient. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and personal care assistance care plan.

Subd. 10. **Responsible party; duties; delegation.** (a) A responsible party shall enter into a written agreement with a personal care assistance provider agency, on a form determined by the commissioner, to perform the following duties:

(1) be available while care is provided in a method agreed upon by the individual or the individual's legal representative and documented in the recipient's personal care assistance care plan;

(2) monitor personal care assistance services to ensure the recipient's personal care assistance care plan is being followed; and

(3) review and sign personal care assistance time sheets after services are provided to provide verification of the personal care assistance services.

Failure to provide the support required by the recipient must result in a referral to the county common entry point.

(b) Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult who is not the personal care assistant during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of the responsible party. The responsible party must ensure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the personal care assistance care plan. The responsible party must communicate to the personal care assistance provider agency about the need for a delegated responsible party, including the name of the delegated responsible party and contact numbers.

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

Subd. 11a. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistant provider agency upon initiation of a new background study according to chapter 245C, if all of the following are met:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of subdivision 11, excluding paragraph (a), clause (3).

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be Web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

(c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home. The following criteria must be included in the time sheet:

(1) full name of personal care assistant and individual provider number;

(2) provider name and telephone numbers;

(3) full name of recipient;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and

(9) dates and location of recipient stays in a hospital, care facility, or incarceration.

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency and meet the definition under section 256B.0625, subdivision 19c. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

(1) is not disqualified under section 245C.14; or

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective July 1, 2011, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

(3) after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.

(d) Communication with the recipient is a part of the evaluation process of the personal care assistance staff.

(e) At each supervisory visit, the qualified professional shall evaluate personal care assistance services including the following information:

(1) satisfaction level of the recipient with personal care assistance services;

(2) review of the month-to-month plan for use of personal care assistance services;

(3) review of documentation of personal care assistance services provided;

(4) whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and service plan;

(5) a written record of the results of the evaluation and actions taken to correct any deficiencies in the work of a personal care assistant; and

(6) revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

(f) The qualified professional shall complete the required documentation in the agency recipient and employee files and the recipient's home, including the following documentation:

(1) the personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) a month-to-month plan for use of personal care assistance services;

(3) changes in need of the recipient requiring a change to the level of service and the personal care assistance care plan;

(4) evaluation results of supervision visits and identified issues with personal care assistance staff with actions taken;

(5) all communication with the recipient and personal care assistance staff; and

(6) hands-on training or individualized training for the care of the recipient.

(g) The documentation in paragraph (f) must be done on agency templates.

(h) The services that are not eligible for payment as qualified professional services include:

(1) direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks;

(2) agency administrative activities;

(3) training other than the individualized training required to provide care for a recipient; and

(4) any other activity that is not described in this section.

Subd. 15. **Flexible use.** (a) "Flexible use" means the scheduled use of authorized hours of personal care assistance services, which vary within a service authorization period covering no more than six months, in order to more effectively meet the needs and schedule of the recipient. Each 12-month service agreement is divided into two six-month authorization date spans. No more than 75 percent of the total authorized units for a 12-month service agreement may be used in a six-month date span.

(b) Authorization of flexible use occurs during the authorization process under section 256B.0652. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient. The commissioner shall not authorize additional personal care assistance services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the assessor determines a change in condition and a need for increased services is established. Authorized hours not used within the six-month period must not be carried over to another time period.

(c) A recipient who has terminated personal care assistance services before the end of the 12-month authorization period must not receive additional hours upon reapplying during the same

12-month authorization period, except if a change in condition is documented. Services must be prorated for the remainder of the 12-month authorization period based on the first six-month assessment.

(d) The recipient, responsible party, and qualified professional must develop a written month-to-month plan of the projected use of personal care assistance services that is part of the personal care assistance care plan and ensures:

(1) that the health and safety needs of the recipient are met throughout both date spans of the authorization period; and

(2) that the total authorized amount of personal care assistance services for each date span must not be used before the end of each date span in the authorization period.

(e) The personal care assistance provider agency shall monitor the use of personal care assistance services to ensure health and safety needs of the recipient are met throughout both date spans of the authorization period. The commissioner or the commissioner's designee shall provide written notice to the provider and the recipient or responsible party when a recipient is at risk of exceeding the personal care assistance services prior to the end of the six-month period.

(f) Misuse and abuse of the flexible use of personal care assistance services resulting in the overuse of units in a manner where the recipient will not have enough units to meet their needs for assistance and ensure health and safety for the entire six-month date span may lead to an action by the commissioner. The commissioner may take action including, but not limited to: (1) restricting recipients to service authorizations of no more than one month in duration; (2) requiring the recipient to have a responsible party; and (3) requiring a qualified professional to monitor and report services on a monthly basis.

Subd. 16. **Shared services.** (a) Medical assistance payments for shared personal care assistance services are limited according to this subdivision.

(b) Shared service is the provision of personal care assistance services by a personal care assistant to two or three recipients, eligible for medical assistance, who voluntarily enter into an agreement to receive services at the same time and in the same setting.

(c) For the purposes of this subdivision, "setting" means:

(1) the home residence or family foster care home of one or more of the individual recipients; or

(2) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) Shared personal care assistance services follow the same criteria for covered services as subdivision 2.

(e) Noncovered shared personal care assistance services include the following:

(1) services for more than three recipients by one personal care assistant at one time;

(2) staff requirements for child care programs under chapter 245C;

(3) caring for multiple recipients in more than one setting;

(4) additional units of personal care assistance based on the selection of the option; and

(5) use of more than one personal care assistance provider agency for the shared care services.

(f) The option of shared personal care assistance is elected by the recipient or the responsible party with the assistance of the assessor. The option must be determined appropriate based on the ages of the recipients, compatibility, and coordination of their assessed care needs. The recipient or the responsible party, in conjunction with the qualified professional, shall arrange the setting and grouping of shared services based on the individual needs and preferences of the recipients. The personal care assistance provider agency shall offer the recipient or the responsible party the option of shared or one-on-one personal care assistance services or a combination of both. The recipient or the responsible party may withdraw from participating in a shared services arrangement at any time.

(g) Authorization for the shared service option must be determined by the commissioner based on the criteria that the shared service is appropriate to meet all of the recipients' needs and their health and safety is maintained. The authorization of shared services is part of the overall

authorization of personal care assistance services. Nothing in this subdivision must be construed to reduce the total number of hours authorized for an individual recipient.

(h) A personal care assistant providing shared personal care assistance services must:

(1) receive training specific for each recipient served; and

(2) follow all required documentation requirements for time and services provided.

(i) A qualified professional shall:

(1) evaluate the ability of the personal care assistant to provide services for all of the recipients in a shared setting;

(2) visit the shared setting as services are being provided at least once every six months or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff;

(3) provide ongoing monitoring and evaluation of the effectiveness and appropriateness of the shared services;

(4) develop a contingency plan with each of the recipients which accounts for absence of the recipient in a shared services setting due to illness or other circumstances;

(5) obtain permission from each of the recipients who are sharing a personal care assistant for number of shared hours for services provided inside and outside the home residence; and

(6) document the training completed by the personal care assistants specific to the shared setting and recipients sharing services.

Subd. 17. **Shared services; rates.** The commissioner shall provide a rate system for shared personal care assistance services. For two persons sharing services, the rate paid to a provider must not exceed one and one-half times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed twice the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared care personal care assistance service have been met.

Subd. 18. **Personal care assistance choice option; generally.** (a) The commissioner may allow a recipient of personal care assistance services to use a fiscal intermediary to assist the recipient in paying and accounting for medically necessary covered personal care assistance services. Unless otherwise provided in this section, all other statutory and regulatory provisions relating to personal care assistance services apply to a recipient using the personal care assistance choice option.

(b) Personal care assistance choice is an option of the personal care assistance program that allows the recipient who receives personal care assistance services to be responsible for the hiring, training, scheduling, and firing of personal care assistants according to the terms of the written agreement with the personal care assistance choice agency required under subdivision 20, paragraph (a). This program offers greater control and choice for the recipient in who provides the personal care assistance service and when the service is scheduled. The recipient or the recipient's responsible party must choose a personal care assistance choice provider agency as a fiscal intermediary. This personal care assistance choice provider agency manages payroll, invoices the state, is responsible for all payroll-related taxes and insurance, and is responsible for providing the consumer training and support in managing the recipient's personal care assistance services.

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) effective January 1, 2010, supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

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

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

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

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Subd. 20. **Personal care assistance choice option; administration.** (a) Before services commence under the personal care assistance choice option, and annually thereafter, the personal care assistance choice provider agency and the recipient or responsible party shall enter into a written agreement. The annual agreement must be provided to the recipient or responsible party, each personal care assistant, and the qualified professional when completed, and include at a minimum:

(1) duties of the recipient, qualified professional, personal care assistant, and personal care assistance choice provider agency;

(2) salary and benefits for the personal care assistant and the qualified professional;

(3) administrative fee of the personal care assistance choice provider agency and services paid for with that fee, including background study fees;

(4) grievance procedures to respond to complaints;

(5) procedures for hiring and terminating the personal care assistant; and

(6) documentation requirements including, but not limited to, time sheets, activity records, and the personal care assistance care plan.

(b) Effective January 1, 2010, except for the administrative fee of the personal care assistance choice provider agency as reported on the written agreement, the remainder of the rates paid to the personal care assistance choice provider agency must be used to pay for the salary and benefits for

the personal care assistant or the qualified professional. The provider agency must use a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation.

(c) The commissioner shall deny, revoke, or suspend the authorization to use the personal care assistance choice option if:

(1) it has been determined by the qualified professional or public health nurse that the use of this option jeopardizes the recipient's health and safety;

(2) the parties have failed to comply with the written agreement specified in this subdivision;

(3) the use of the option has led to abusive or fraudulent billing for personal care assistance services; or

(4) the department terminates the personal care assistance choice option.

(d) The recipient or responsible party may appeal the commissioner's decision in paragraph (c) according to section 256.045. The denial, revocation, or suspension to use the personal care assistance choice option must not affect the recipient's authorized level of personal care assistance services.

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

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

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

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

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

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Subd. 22. **Annual review for personal care providers.** (a) All personal care assistance provider agencies shall resubmit, on an annual basis, the information specified in subdivision 21, in a format determined by the commissioner, and provide a copy of the personal care assistance provider agency's most current version of its grievance policies and procedures along with a written record of grievances and resolutions of the grievances that the personal care assistance provider agency has received in the previous year and any other information requested by the commissioner.

(b) The commissioner shall send annual review notification to personal care assistance provider agencies 30 days prior to renewal. The notification must:

(1) list the materials and information the personal care assistance provider agency is required to submit;

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

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

Personal care assistance provider agencies shall submit required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the personal care assistance provider agency enrollment number must be terminated or suspended.

(c) Personal care assistance provider agencies also currently licensed under section 144A.471, subdivision 6 or 7, or currently certified for participation in Medicare as a home health agency are deemed in compliance with the personal care assistance requirements for enrollment, annual review process, and documentation.

Subd. 23. **Enrollment requirements following termination.** (a) A terminated personal care assistance provider agency, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the personal care assistance provider agency, is not eligible to enroll as a personal care assistance provider agency for two years following the termination.

(b) After the two-year period in paragraph (a), if the provider seeks to reenroll as a personal care assistance provider agency, the personal care assistance provider agency must be placed on a one-year probation period, beginning after completion of the following:

(1) the department's provider trainings under this section; and

(2) initial enrollment requirements under subdivision 21.

(c) During the probationary period the commissioner shall complete site visits and request submission of documentation to review compliance with program policy.

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

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

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

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

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

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

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

(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

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

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

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

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

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

Subd. 25. **Personal care assistance provider agency; background studies.** Personal care assistance provider agencies enrolled to provide personal care assistance services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care assistance provider agencies and those agencies seeking enrollment as a personal care assistance

provider agency. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners and managing employees; or

(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all qualified professionals; and

(3) a background study must be initiated and completed for all personal care assistants.

Subd. 26. **Personal care assistance provider agency; communicable disease prevention.** A personal care assistance provider agency shall establish and implement policies and procedures for prevention, control, and investigation of infections and communicable diseases according to current nationally recognized infection control practices or guidelines established by the United States Centers for Disease Control and Prevention, as well as applicable regulations of other federal or state agencies.

Subd. 27. **Personal care assistance provider agency.** (a) The personal care assistance provider agency is required to provide training for the personal care assistant responsible for working with a recipient who is ventilator dependent. All training must be administered by a respiratory therapist, nurse, or physician. Qualified professional supervision by a nurse must be completed and documented on file in the personal care assistant's employment record and the recipient's health record. If offering personal care services to a ventilator-dependent recipient, the personal care assistance provider agency shall demonstrate and document the ability to:

(1) train the personal care assistant;

(2) supervise the personal care assistant in the care of a ventilator-dependent recipient;

(3) supervise the recipient and responsible party in the care of a ventilator-dependent recipient; and

(4) provide documentation of the training and supervision in clauses (1) to (3) upon request.

(b) A personal care assistant shall not undertake any clinical services, patient assessment, patient evaluation, or clinical education regarding the ventilator or the patient on the ventilator. These services may only be provided by health care professionals licensed or registered in this state.

(c) A personal care assistant may only perform tasks associated with ventilator maintenance that are approved by the Board of Medical Practice in consultation with the Respiratory Care Practitioner Advisory Council and the Department of Human Services.

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

Subd. 29. **Transitional assistance.** The commissioner, counties, health plans, tribes, and personal care assistance providers shall work together to provide transitional assistance for recipients and families to come into compliance with the new requirements of this section that may require a change in living arrangement no later than August 10, 2010.

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information; and

(2) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

Subd. 31. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and/or terminating the personal care provider organization's enrollment according to section 256B.064.