A bill for an act

relating to human services; reforming the elderly waiver program; requiring a report; appropriating money; amending Minnesota Statutes 2016, sections 256B.056, subdivision 5; 256B.0911, subdivision 3a; 256B.0915, subdivisions 3a, 3e, 3h, 5, by adding subdivisions; 256B.439, by adding a subdivision.

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

Section 1. Minnesota Statutes 2016, section 256B.056, subdivision 5, is amended to read:

Subd. 5. **Excess income.** (a) A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 5c. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall allow persons eligible for assistance on a one-month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the state agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 20th of the month, the recipient is ineligible for this option for the following month. The local agency shall code the Medicaid Management Information System (MMIS) to indicate that the recipient has elected this option. The state agency shall convey recipient eligibility information relative to the collection of the spenddown to providers through the Electronic Verification System (EVS). A recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 20th of the month in order to be eligible for this option in the following month.

(b) A person who is eligible for medical assistance and receiving services under section 256B.0915 shall be eligible to pay the person's monthly spenddown or waiver obligation amount due to a provider of the person's choice. The state, or other payer acting on behalf of the state, shall deduct that amount from the provider's claims for each month.

Sec. 2. Minnesota Statutes 2016, 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 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 necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative. 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. 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 person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual 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 a copy of the draft assessment and have an opportunity to submit additional information to the assessor before the assessment is final. The provider shall also receive a copy of the final written community support plan when available, the case mix level, 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 options and choices to meet identified needs, including all available options for case management services and providers;

(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.

~~(f)~~ (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.

~~(g)~~ (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).

~~(h)~~ (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. 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 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 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.

~~(i)~~ (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 waiver programs under sections 256B.0913, 256B.0915, and 256B.49 is valid to establish service eligibility for no more than ~~60~~ 90 calendar days after the date of assessment.

~~(j)~~ (l) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than ~~60~~ 90 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 ~~(i)~~ (k) cannot be prior to the date the most recent updated assessment is completed.

Sec. 3. Minnesota Statutes 2016, 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 256B.438 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 affected 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), 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 ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 4. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by

the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) The commissioner shall include a nursing component service that includes, but is not limited to injections, catheterizations, wound care, infections, and diabetic and foot care. The hourly unit service payment shall be based on the registered nurses component rate.

~~(d)~~ (e) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the ~~greater of either the~~ statewide ~~or any of the geographic groups'~~ weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). ~~Effective~~ On July 1 of ~~the state fiscal~~ each year ~~in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year~~, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(f) The monthly customized living service rate for a client may be increased temporarily in lieu of the client being admitted to a hospital. The temporary increase shall cover additional nursing and home care services needed to avoid hospitalization. A provider shall communicate client need to the case manager in a form and manner prescribed by the commissioner.

(g) Based on responses to questions 45 and 51 of the Minnesota long-term care consultation assessment form, the elderly waiver payment for customized living services includes a cognitive and behavioral needs factor for a client determined to have either:

(1) wandering or orientation issues; or

(2) anxiety, verbal aggression, physical aggression, repetitive behavior, agitation, self-injurious behavior, or behavior related to property destruction.

An additional 15 percent is applied to the component service rates if the total monthly hours of customized living services divided by 30.4 is less than 3.62. A client assessed as both "oriented" and "behavior requires no intervention" or "no behaviors" shall not receive a cognitive and behavioral needs factor.

~~(e) Effective July 1, 2011,~~ (h) The individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(i) The payment rate for a client qualifying for customized living services equals 120 percent of the statewide average 24-hour residential services rate for the first 62 days and equals the rate established by the responsible case manager for the 63rd and subsequent days.

~~(f)~~ (j) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

~~(g)~~ (k) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

~~(h)~~ (l) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and

the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431~~,~~ and 256B.434~~,~~ and ~~256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 5. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ 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 ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 6. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months ~~and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital~~. There must be a determination that the client requires 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.

(b) 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 and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

(c) The lead agency shall conduct a change-in-condition reassessment before the annual reassessment in cases where a client's condition changed due to a major health event, an emerging need or risk, worsening health condition, or cases where the current services do not meet the client's needs. A change-in-condition reassessment may be initiated by the lead

agency, or it may be requested by the client or requested on the client's behalf by another party, such as a provider of services. The lead agency shall complete a change-in-condition reassessment no later than 20 calendar days from the request. The lead agency shall conduct these assessments in a timely manner and expedite urgent requests. The lead agency shall evaluate urgent requests based on the client's needs and risk to the client if a reassessment is not completed.

Sec. 7. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12 to 15 apply to elderly waiver and elderly waiver customized living under this section, alternative care under section 256B.0913, essential community supports under section 256B.0922, community access for disability inclusion customized living, brain injury customized living, and elderly waiver foster care and residential care.

Sec. 8. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 12. **Payment rates; establishment.** (a) The commissioner shall use standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook and data from the most recent and available nursing facility cost report to establish rates and component rates every January 1 using Minnesota-specific wages taken from job descriptions.

(b) In creating the rates and component rates, the commissioner shall establish a base wage calculation for each component service and value and add the following factors:

(1) payroll taxes and benefits;

(2) general and administrative;

(3) program plan support;

(4) registered nurse management and supervision; and

(5) social worker supervision.

Sec. 9. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 13. **Payment rates; base wage index.** (a) Base wages are calculated for customized living, foster care, and residential care component services as follows:

(1) the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(2) the home care aide base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014);

(3) the home health aide base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and

(4) the medication setups by licensed practical nurse base wage equals ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

(b) Base wages are calculated for the following services as follows:

(1) the chore services base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011);

(2) the companion services base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(3) the homemaker services and assistance with personal care base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(4) the homemaker services and cleaning base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(5) the homemaker services and home management base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(6) the in-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and

(7) the out-of-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

(c) Base wages are calculated for the following values as follows:

(1) the registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); and

(2) the social worker base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social workers (SOC code 21-1022).

(d) If any of the SOC codes and positions are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Sec. 10. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 14. **Payment rates; factors.** The commissioner shall use the following factors:

(1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits divided by the sum of all salaries for all nursing facilities on the most recent and available cost report;

(2) the general and administrative factor is the sum of net general and administrative expenses minus administrative salaries divided by total operating expenses for all nursing facilities on the most recent and available cost report;

(3) the program plan support factor is defined as the direct service staff needed to provide support for the home and community-based service when not engaged in direct contact with clients. Based on the 2016 Non-Wage Provider Costs in Home and Community-Based Disability Waiver Services Report, this factor equals 12.8 percent;

(4) the registered nurse management and supervision factor equals 15 percent of the registered nurse value; and

(5) the social worker supervision factor equals 15 percent of the social worker value.

Sec. 11. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision to read:

Subd. 15. **Payment rates; component rates.** (a) For the purposes of this subdivision, the "adjusted base wage" for a position equals the position's base wage plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor;

(2) the position's base wage multiplied by the general and administrative factor; and

(3) the position's base wage multiplied by the program plan support factor.

(b) For medication setups by licensed nurse, registered nurse, and social worker services, the component rate for each service equals the respective position's adjusted base wage.

(c) For home management and support services, home care aide, and home health aide services, the component rate for each service equals the respective position's adjusted base wage plus the registered nurse management and supervision factor.

(d) The home management and support services component rate shall be used for payment for socialization and transportation component rates under elderly waiver customized living.

(e) The 15-minute unit rates for chore services and companion services are calculated as follows:

(1) sum the adjusted base wage for the respective position and the social worker factor; and

(2) divide the result of clause (1) by four.

(f) The 15-minute unit rates for homemaker services and assistance with personal cares, homemaker services and cleaning, and homemaker services and home management are calculated as follows:

(1) sum the adjusted base wage for the respective position and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(g) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the adjusted base wage for in-home respite care services and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(h) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

(i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision factor; and

(2) divide the result of clause (1) by four.

(j) The out-of-home respite care services daily rate equals the out-of-home respite care services 15-minute unit rate multiplied by 18.

(k) The individual community living support rate is calculated as follows:

(1) sum the adjusted base wage for the home care aide rate in subdivision 13, paragraph (a), clause (2), and the social worker factor; and

(2) divide the result of clause (1) by four.

(l) The home delivered meals rate equals $9.30. Beginning July 1, 2018, the commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent nursing facility cost reports.

(m) The adult day services rate is based on the home care aide rate under subdivision 13, paragraph (a), clause (2), plus the additional factors in subdivision 14, except that the general and administrative factor used shall be 20 percent. The nonregistered nurse portion of the rate shall be multiplied by 0.25, to reflect a staffing ratio of one caregiver to four clients, and divided by four to determine the 15-minute unit rate. The registered nurse portion is divided by four to determine the 15-minute unit rate and $0.63 per 15-minute unit is added to cover the cost of meals.

(n) The adult day services bath 15-minute unit rate is the same as the calculation of the adult day services 15-minute unit rate without the adjustment for staffing ratio.

(o) If a bath is authorized for an adult day services client, at least two 15-minute units must be authorized to allow for adequate time to meet client needs. Adult day services may be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver needs.

Sec. 12. Minnesota Statutes 2016, section 256B.439, is amended by adding a subdivision to read:

Subd. 2b. **Performance measures for elderly waiver customized living.** The commissioner shall develop performance measures for housing with services establishments that are enrolled in the elderly waiver program as a provider of customized living or 24-hour customized living. According to methods determined by the commissioner in consultation with stakeholders and experts, the commissioner shall develop the following performance measures:

(1) an annual customer satisfaction survey measure for assisted living residents and family members using a validated survey tool and set of questions chosen by the commissioner in consultation with stakeholders;

(2) a measure utilizing level 3 or 4 citations from Department of Health home care survey findings and substantiated Office of Health Facility Complaints findings against a home care agency;

(3) a home care staff retention measure; and

(4) a measure that scores a provider's staff according to their level of training and education.

Sec. 13. **DIRECTION TO COMMISSIONER; ADULT DAY SERVICES STAFFING RATIOS.**

The commissioner of human services shall study the staffing ratio for adult day services clients and shall provide the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over adult day services with recommendations to adjust staffing ratios based on client needs by January 1, 2018.

Sec. 14. **DIRECTION TO COMMISSIONER; EVALUATION OF RATE METHODOLOGY.**

(a) The commissioner of human services, in consultation with stakeholders, shall conduct a study to evaluate the following:

(1) base wages in Minnesota Statutes, section 256B.0915, subdivision 13, to determine if the standard occupational classification codes for each rate and component rate are an appropriate representation of staff who deliver such services; and

(2) factors in Minnesota Statutes, section 256B.0915, subdivision 14, and adjusted base wage calculations in Minnesota Statutes, section 256B.0915, subdivision 15, to determine if the factors and calculations appropriately address nonwage provider costs.

(b) By January 1, 2019, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance on the changes to the rate methodology in Minnesota Statutes, section 256B.0915, based on the results of the evaluation. Where feasible, the report shall address the impact of the new rates on the workforce situation and client access to services. The report must include any changes to the rate calculations that the commissioner recommends.

Sec. 15. **APPROPRIATION; PERFORMANCE MEASURES FOR ELDERLY WAIVER CUSTOMIZED LIVING.**

$5,000,000 in fiscal year 2018 is appropriated from the general fund to the commissioner of human services for purposes of developing performance measures for elderly waiver customized living under Minnesota Statutes, section 256B.439, subdivision 2b. This is a onetime appropriation.

Sec. 16. **REVISOR'S INSTRUCTION.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall

prepare legislation for the 2018 legislative session to recodify laws governing the elderly waiver program in Minnesota Statutes, chapter 256B.

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