ARTICLE 1

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144A.351, is amended to read:

144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT ~~AND STUDY~~ REQUIRED.

Subdivision 1. **Report requirements.** The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. Any amounts appropriated for this report are available in either year of the biennium. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

~~Subd. 2. **Critical access study.** The commissioner of human services shall conduct a onetime study to assess local capacity and availability of home and community-based services for older adults, people with disabilities, and people with mental illnesses. The study must assess critical access at the community level and identify potential strategies to~~

ARTICLE 2

CONTINUING CARE

~~build home and community-based service capacity in critical access areas. The report shall be submitted to the legislature no later than August 15, 2015.~~

Sec. 2. Minnesota Statutes 2016, 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, 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 waiver plan; ~~and~~

(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

Sec. 4. Minnesota Statutes 2016, 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, 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 waiver plan; and

(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.

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

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

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(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; ~~and~~

(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

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

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(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; and

(iii) semi-independent living services;

(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) ~~supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans~~ 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.

EFFECTIVE DATE. (a) The amendment to paragraphs (b) and (c), clause (2), is effective the day following final enactment.

(b) The amendments to paragraph (c), clauses (5) to (7), are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day training and habilitation services for adults with developmental disabilities.** (a) "Day training and habilitation services for adults with developmental disabilities" means services that:

(1) include supervision, training, assistance, ~~and supported employment,~~ center-based work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the

(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) ~~supported employment as defined under the brain injury, developmental disability, and community access for disability inclusion waiver plans.~~ 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.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day training and habilitation services for adults with developmental disabilities.** (a) "Day training and habilitation services for adults with developmental disabilities" means services that:

(1) include supervision, training, assistance, ~~and supported employment,~~ center-based work-related activities, or other community-integrated activities designed and implemented in accordance with the individual service and individual habilitation plans required under Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the

highest possible level of independence, productivity, and integration into the community; and

(2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services.

(b) Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day training and habilitation services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **[256.477] SELF-ADVOCACY GRANTS.**

(a) The commissioner shall make available a grant for the purposes of establishing and maintaining a statewide self-advocacy network for persons with intellectual and developmental disabilities. The self-advocacy network shall:

(1) ensure that persons with intellectual and developmental disabilities are informed of their rights in employment, housing, transportation, voting, government policy, and other issues pertinent to the intellectual and developmental disability community;

(2) provide public education and awareness of the civil and human rights issues persons with intellectual and developmental disabilities face;

(3) provide funds, technical assistance, and other resources for self-advocacy groups across the state; and

(4) organize systems of communications to facilitate an exchange of information between self-advocacy groups.

(b) An organization receiving a grant under paragraph (a) must be an organization governed by people with intellectual and developmental disabilities that administers a statewide network of disability groups in order to maintain and promote self-advocacy

highest possible level of independence, productivity, and integration into the community; and

(2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to provide day training and habilitation services.

(b) Day training and habilitation services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day training and habilitation services do not include employment exploration, employment development, or employment supports services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Senate Language S0800-3

services and supports for persons with intellectual and developmental disabilities throughout the state.

(c) An organization receiving a grant under paragraph (a) must use the funds for the following purposes:

(1) to maintain the infrastructure needed to train and support the activities of a statewide network of peer-to-peer mentors for people with developmental disabilities, focused on building awareness of service options and advocacy skills necessary to move toward full inclusion in community life, including the development and delivery of the curriculum to support the peer-to-peer network;

(2) to provide outreach activities, including statewide conferences and disability networking opportunities focused on self-advocacy, informed choice, and community engagement skills;

(3) to provide an annual leadership program for persons with intellectual and developmental disabilities; and

(4) to provide for administrative and general operating costs associated with managing and maintaining facilities, program delivery, evaluation, staff, and technology.

House Language UES0800-2

Sec. 8. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance covers home health services at a recipient's home residence or in the community where normal life activities take the recipient. Medical assistance does not cover home health services for residents of a hospital, nursing facility, or intermediate care facility, unless the commissioner of human services has authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with developmental disabilities, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to sections 256B.0651 to 256B.0653.

Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Assessment" means an evaluation of the recipient's medical need for home health agency services by a registered nurse or appropriate therapist that is conducted within 30 days of a request.

(b) "Home care therapies" means occupational, physical, and respiratory therapy and speech-language pathology services provided in the home by a Medicare certified home health agency.

(c) "Home health agency services" means services delivered ~~in the recipient's home residence, except as specified in section 256B.0625,~~ by a home health agency to a recipient with medical needs due to illness, disability, or physical conditions in settings permitted under section 256B.0625, subdivision 6a.

(d) "Home health aide" means an employee of a home health agency who completes medically oriented tasks written in the plan of care for a recipient.

(e) "Home health agency" means a home care provider agency that is Medicare-certified.

(f) "Occupational therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(g) "Physical therapy services" mean the services defined in Minnesota Rules, part 9505.0390.

(h) "Respiratory therapy services" mean the services defined in chapter 147C.

(i) "Speech-language pathology services" mean the services defined in Minnesota Rules, part 9505.0390.

(j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks required due to a recipient's medical condition that can only be safely provided by a professional nurse to restore and maintain optimal health.

(k) "Store-and-forward technology" means telehomecare services that do not occur in real time via synchronous transmissions such as diabetic and vital sign monitoring.

(l) "Telehomecare" means the use of telecommunications technology via live, two-way interactive audiovisual technology which may be augmented by store-and-forward technology.

(m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver a skilled nurse visit to a recipient located at a site other than the site where the nurse is located and is used in combination with face-to-face skilled nurse visits to adequately meet the recipient's needs.

Sec. 10. Minnesota Statutes 2016, 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 ~~must~~ 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.

Sec. 11. Minnesota Statutes 2016, section 256B.0653, subdivision 4, is amended to read:

Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse, according to the written plan of care and accepted standards of medical and nursing practice according to chapter 148. Skilled nurse visit services must be ordered by a physician and documented in a plan of care that is reviewed and approved by the ordering physician at least once every 60 days. All skilled nurse visits must be medically necessary and provided in the recipient's home residence or in the community where normal life activities take the recipient, except as allowed under section 256B.0625, subdivision 6a.

(b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up to two visits per day per recipient. All visits must be based on assessed needs.

(c) Telehomecare skilled nurse visits are allowed when the recipient's health status can be accurately measured and assessed without a need for a face-to-face, hands-on encounter. All telehomecare skilled nurse visits must have authorization and are paid at the same allowable rates as face-to-face skilled nurse visits.

(d) The provision of telehomecare must be made via live, two-way interactive audiovisual technology and may be augmented by utilizing store-and-forward technologies. Individually identifiable patient data obtained through real-time or store-and-forward technology must be maintained as health records according to sections 144.291 to 144.298. If the video is used for research, training, or other purposes unrelated to the care of the patient, the identity of the patient must be concealed.

(e) Authorization for skilled nurse visits must be completed under section 256B.0652. A total of nine face-to-face skilled nurse visits per calendar year do not require authorization. All telehomecare skilled nurse visits require authorization.

Sec. 12. Minnesota Statutes 2016, section 256B.0653, subdivision 5, is amended to read:

Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical therapy, occupational therapy, respiratory therapy, and speech and language pathology therapy services.

(b) Home care therapies must be:

(1) provided in the recipient's residence or in the community where normal life activities take the recipient after it has been determined the recipient is unable to access outpatient therapy;

(2) prescribed, ordered, or referred by a physician and documented in a plan of care and reviewed, according to Minnesota Rules, part 9505.0390;

(3) assessed by an appropriate therapist; and

(4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider agency.

(c) Restorative and specialized maintenance therapies must be provided according to Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

(d) For both physical and occupational therapies, the therapist and the therapist's assistant may not both bill for services provided to a recipient on the same day.

Sec. 13. Minnesota Statutes 2016, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. **Noncovered home health agency services.** The following are not eligible for payment under medical assistance as a home health agency service:

(1) telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

(2) the following skilled nurse visits:

(i) for the purpose of monitoring medication compliance with an established medication program for a recipient;

(ii) administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;

(iii) services done for the sole purpose of supervision of the home health aide or personal care assistant;

(iv) services done for the sole purpose to train other home health agency workers;

(v) services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and

(vi) Medicare evaluation or administrative nursing visits required by Medicare;

(3) home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education; ~~and~~

8.10 Sec. 5. Minnesota Statutes 2016, section 256B.0659, subdivision 1, is amended to read:

8.11 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
8.12 paragraphs (b) to ~~(r)~~ (s) have the meanings given unless otherwise provided in text.

91.16 (4) home care therapies provided in other settings such as a clinic~~, day program,~~ or as
91.17 an inpatient or when the recipient can access therapy outside of the recipient's residence;
91.18 and

91.19 (5) home health agency services without qualifying documentation of a face-to-face
91.20 encounter as specified in subdivision 7.

91.21 Sec. 14. Minnesota Statutes 2016, section 256B.0653, is amended by adding a subdivision
91.22 to read:

91.23 Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider
91.24 must be completed for all home health services regardless of the need for prior authorization,
91.25 except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter
91.26 may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The
91.27 encounter must be related to the primary reason the recipient requires home health services
91.28 and must occur within the 90 days before or the 30 days after the start of services. The
91.29 face-to-face encounter may be conducted by one of the following practitioners, licensed in
91.30 Minnesota:

91.31 (1) a physician;

91.32 (2) a nurse practitioner or clinical nurse specialist;

92.1 (3) a certified nurse midwife; or

92.2 (4) a physician assistant.

92.3 (b) The allowed nonphysician practitioner, as described in this subdivision, performing
92.4 the face-to-face encounter must communicate the clinical findings of that face-to-face
92.5 encounter to the ordering physician. Those clinical findings must be incorporated into a
92.6 written or electronic document included in the recipient's medical record. To assure clinical
92.7 correlation between the face-to-face encounter and the associated home health services, the
92.8 physician responsible for ordering the services must:

92.9 (1) document that the face-to-face encounter, which is related to the primary reason the
92.10 recipient requires home health services, occurred within the required time period; and

92.11 (2) indicate the practitioner who conducted the encounter and the date of the encounter.

92.12 (c) For home health services requiring authorization, including prior authorization, home
92.13 health agencies must retain the qualifying documentation of a face-to-face encounter as part
92.14 of the recipient health service record, and submit the qualifying documentation to the
92.15 commissioner or the commissioner's designee upon request.

(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) "Complex personal care assistance services" means personal care assistance services:

(1) for a person who qualifies for ten hours or more of personal care assistance services per day; and

(2) provided by a personal care assistant who is qualified to provide complex personal assistance services under subdivision 11, paragraph (d).

~~(e)~~ (f) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

~~(f)~~ (g) "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)~~ (h) "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)~~ (i) "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)~~ (j) "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)~~ (k) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

~~(k)~~ (l) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

~~(l)~~ (m) "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)~~ (n) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

~~(n)~~ (o) "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)~~ (p) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

~~(p)~~ (q) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

~~(q)~~ (r) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

~~(r)~~ (s) "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.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 6. Minnesota Statutes 2016, section 256B.0659, subdivision 2, is amended to read:

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)~~ (j).

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

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.

(d) A personal care assistant is qualified to provide complex personal care assistance services defined in subdivision 1, paragraph (e), if the personal care assistant:

(1) provides services according to the care plan in subdivision 7 to an individual described in subdivision 1, paragraph (e), clause (1); and

(2) beginning July 1, 2018, satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative, comparable, state-approved training and competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Rate for complex personal care assistance services.** The rate paid to a provider for complex personal care assistance services shall be 110 percent of the rate paid for personal care assistance services.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

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, including the requirements under subdivision 11, paragraph (d), if complex personal care assistance services are provided and submitted for payment;

(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.

Sec. 10. Minnesota Statutes 2016, 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, 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 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 case management services available under sections 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

(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) 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" includes the active participation of a person with a disability in the person's services and program, including in making meaningful and informed choices about the person's own goals and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this paragraph, "informed choice" means the process of the person with a disability choosing 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 by a partnership consisting of the person and the individuals that will empower the consumer to make decisions.

Sec. 11. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Initial assessment and support planning.** (a) Persons requesting initial assessment, initial services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine initial 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 initial assessment was requested or recommended. ~~Upon statewide implementation of subdivisions 2b, 2e, and 5,~~ This requirement also applies to an initial 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 initial assessments must be conducted according to paragraphs (b) to (i).

(b) ~~Upon implementation of subdivisions 2b, 2e, and 5,~~ Lead agencies shall use certified assessors to conduct the initial 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~~ an initial comprehensive, person-centered assessment. The initial 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 initial 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 initially assessed for elderly waiver customized living 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 initially 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 initial assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. 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 practical 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) 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) 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) The lead agency must give the person receiving initial 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, including independent living, 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 or corporate foster 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, the certified assessor's decision regarding the person's need for corporate foster care, and the certified assessor's decision regarding the person's 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 certified assessor's decision regarding the need for institutional level of care, the certified assessor's decision regarding the need for corporate foster care, or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of an initial 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 calendar days after the date of assessment.

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of initial assessment. If an initial 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 (i) cannot be prior to the date the ~~most recent updated~~ initial assessment is completed.

Sec. 12. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3f. **Service updates and modifications.** (a) A service update may substitute for an annual reassessment under this section and Minnesota Rules, part 9525.0016, whenever permitted by federal law and either there is not a significant change in a person's condition or there is not a change in the person's needs for services. Service updates must be completed face-to-face annually unless completed by phone. A service update may be completed by telephone only if the person is able to participate in the update by telephone and no more than two consecutive service updates are completed by phone.

(b) A service update must include a review of the most recent written community support plan and home care plan, as well as a review of the initial baseline data, evaluation of service effectiveness, modification of service plan and appropriate referrals, update of initial assessment or most recent reassessment forms, obtaining service authorizations, and ongoing consumer education.

(c) To the extent permitted by federal law, a service modification may substitute for a reassessment otherwise required under this chapter following a change in condition or a change in eligibility.

(d) A service update or service modification must be documented in a manner determined by the commissioner.

(e) If the person receiving services or the person's legal representative requests a reassessment under subdivision 3g, a service update or service modification must not be substituted for a reassessment.

Sec. 13. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3g. **Annual reassessments and other reassessments.** (a) All reassessments must be conducted according to subdivision 3a.

(b) Any person who received an initial assessment under subdivision 3a and whose continued eligibility for medical assistance services under federal law requires an annual reassessment must be reassessed annually.

(c) If an annual reassessment is not required under federal law for a person who received an initial assessment under subdivision 3a, lead agencies are not required to perform an annual reassessment unless the person or the person's legal representative requests an annual reassessment or the person has experienced a significant change in condition.

Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face initial assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within 40 calendar days of admission.

(d) At the face-to-face initial assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face initial assessment as described in paragraph (c) must be conducted within 40 calendar days of admission.

(g) At the face-to-face initial assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility whose condition is likely to change shall receive a face-to-face ~~assessment~~ reassessment under subdivision 3g at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a face-to-face ~~assessment~~ reassessment at least once every 36 months for the same purposes.

(i) An individual under 65 years of age residing in a nursing facility whose condition is unlikely to change may, upon request, receive a face-to-face reassessment under subdivision 3g. An individual who does not request a reassessment under this paragraph must receive an annual service update under subdivision 3f.

(j) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for face-to-face initial assessments or reassessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

~~(j)~~ (k) Funding for preadmission screening follow-up shall be provided to the Disability Linkage Line for the under-60 population by the Department of Human Services to cover options counseling salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening follow-up services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (dd).

Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. **Elderly waiver case management services.** (a) Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), case

management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of case management services.

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services and assist individuals in appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated service and support plan.

(c) A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate the process of reassessment of the individual's coordinated service and support plan and review the plan at intervals specified in the federally approved waiver plan.

(e) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

(f) Except as described in paragraph (h), 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 subdivision 1b. Case management services must not be provided to a recipient by a private agency that has a 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).

(g) Case management service activities provided to or arranged for a person include:

(1) development of the coordinated service and support plan under subdivision 6;

(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, which must ~~incorporate at least one annual~~ include a face-to-face visit ~~by the case manager with each person~~ at the request of the individual or the individual's legal guardian or conservator of service options.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Sec. 16. 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~~ according to section 256B.0911, subdivision 3g, when the case manager determines that there has been significant change in the client's functioning or at the request of the client or the client's legal guardian or conservator of service options. 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 an initial assessment under section 256B.0911, subdivision 3a, and any subsequent ~~assessments~~ reassessments under section 256B.0911, subdivision 3g, or annual service updates under section 256B.0911, subdivision 3f, 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 initial 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. Only reassessments conducted according to section 256B.0911, subdivision 3g, that result in a nursing facility level of need determination or annual service updates conducted according to section 256B.0911, subdivision 3f, that demonstrate no

improvement in the client's condition shall be accepted for the purposes of ongoing access to waiver service payments.

Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service 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 meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan ~~at least every 12 months and at other times~~ when there has been a significant change in the recipient's functioning or at the request of the recipient or the recipient's guardian. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community access for disability inclusion or brain injury waivered services currently residing in a licensed adult foster 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 recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

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Sec. 18. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

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Sec. 17. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision, "implementation period" means the period beginning January 1, 2014, and ending on the last day of the month in which the rate management system is populated with the data necessary to calculate rates for substantially all individuals receiving home and community-based waiver services under sections 256B.092 and 256B.49. "Banding period" means the time period beginning on January 1, 2014, and ending upon the expiration of the 12-month period defined in paragraph (c), clause (5).

(b) For purposes of this subdivision, the historical rate for all service recipients means the individual reimbursement rate for a recipient in effect on December 1, 2013, except that:

(1) for a day service recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for the provider number in the county of service, effective December 1, 2013; or

(2) for a unit-based service with programming or a unit-based service without programming recipient who was not authorized to receive these waiver services prior to January 1, 2014; added a new service or services on or after January 1, 2014; or changed providers on or after January 1, 2014, the historical rate must be the weighted average authorized rate for each provider number in the county of service, effective December 1, 2013; or

(3) for residential service recipients who change providers on or after January 1, 2014, the historical rate must be set by each lead agency within their county aggregate budget using their respective methodology for residential services effective December 1, 2013, for determining the provider rate for a similarly situated recipient being served by that provider.

(c) The commissioner shall adjust individual reimbursement rates determined under this section so that the unit rate is no higher or lower than:

(1) 0.5 percent from the historical rate for the implementation period;

(2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately following the time period of clause (1);

(3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately following the time period of clause (2);

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(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4); ~~and~~

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. The commissioner shall, upon enactment, seek federal approval for the addition of this banding period; and

(7) one percent from the rate in effect in clause (6) for the 12-month period immediately following the time period of clause (6).

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

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(4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately following the time period of clause (3);

(5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately following the time period of clause (4); and

(6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately following the time period of clause (5). During this banding rate period, the commissioner shall not enforce any rate decrease or increase that would otherwise result from the end of the banding period. The commissioner shall, upon enactment, seek federal approval for the addition of this banding period.

(d) The commissioner shall review all changes to rates that were in effect on December 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service unit utilization on an annual basis as those in effect on October 31, 2013.

(e) By December 31, 2014, the commissioner shall complete the review in paragraph (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

(f) During the banding period, the Medicaid Management Information System (MMIS) service agreement rate must be adjusted to account for change in an individual's need. The commissioner shall adjust the Medicaid Management Information System (MMIS) service agreement rate by:

(1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the level of service in effect on December 1, 2013;

(2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the individual with variables reflecting the updated level of service at the time of application; and

(3) adding to or subtracting from the Medicaid Management Information System (MMIS) service agreement rate, the difference between the values in clauses (1) and (2).

(g) This subdivision must not apply to rates for recipients served by providers new to a given county after January 1, 2014. Providers of personal supports services who also acted as fiscal support entities must be treated as new providers as of January 1, 2014.

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EFFECTIVE DATE. (a) The amendment to paragraph (b) is effective the day following final enactment.

(b) The amendment to paragraph (c) is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

Subd. 7. **New services.** (a) A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

(b) Employment support services authorized after January 1, 2018, under the new employment support services definition according to the home and community-based services waivers for people with disabilities under sections 256B.092 and 256B.49 are not subject to rate stabilization adjustment in this section.

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

Sec. 20. Minnesota Statutes 2016, 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

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

Sec. 18. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision to read:

Subd. 7. **New services.** (a) A service added to section 256B.4914 after January 1, 2014, is not subject to rate stabilization adjustment in this section.

(b) Employment support services authorized after January 1, 2018, under the new employment support services definition according to the home and community-based services waivers for people with disabilities under sections 256B.092 and 256B.49 are not subject to rate stabilization adjustment in this section.

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

Sec. 19. Minnesota Statutes 2016, 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

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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:

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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:

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(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~~:~~

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

~~(ii) for all other services, a unit of service is 15 minutes.~~

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 21. Minnesota Statutes 2016, 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,

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(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~~:~~

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

~~(ii) for all other services, a unit of service is 15 minutes.~~

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2016, 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,

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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;

(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)~~ (18) supported living services;

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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;

(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)~~ (18) supported living services;

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~~(20)~~ (19) transportation services; ~~and~~

(20) individualized home supports;

(21) independent living skills specialist services;

(22) employment exploration services;

(23) employment development services;

(24) employment support services; and

~~(21)~~ (25) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. (a) Clause (20) is effective the day following final enactment.

(b) Clauses (21) to (24) are effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code

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~~(20)~~ (19) transportation services; ~~and~~

(20) independent living skills specialist services;

(21) employment exploration services;

(22) employment development services;

(23) employment support services; and

~~(21)~~ (24) other services as approved by the federal government in the state home and community-based services plan.

EFFECTIVE DATE. This section is effective upon federal approval, except clause (20) is effective January 1, 2020. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code

29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage ~~will be $7.66 per hour~~ is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is ~~$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median wage for social and human services aide (SOC code 21-1093);~~

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage ~~will be $7.66 per hour~~ is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is ~~$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median wage for social and human services aide (SOC code 21-1093);~~

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

~~(11)~~ (13) for ~~supported~~ employment support services staff, ~~20~~ 50 percent of the median wage for ~~nursing aide~~ rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); ~~20 percent of the median wage for psychiatric technician (SOC code 29-2053);~~ and ~~60~~ 50 percent of the median wage for community and social ~~and human~~ services ~~aide~~ specialist (SOC code ~~21-1093~~ 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(12)~~ (16) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(13)~~ (17) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(14)~~ (18) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(15)~~ (19) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

(10) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

~~(11)~~ (12) for ~~supported~~ employment supports services staff, ~~20~~ 50 percent of the median wage for ~~nursing aide~~ rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); ~~20 percent of the median wage for psychiatric technician (SOC code 29-2053);~~ and ~~60~~ 50 percent of the median wage for community and social ~~and human~~ services ~~aide~~ specialist (SOC code ~~21-1093~~ 21-1099);

(13) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

~~(12)~~ (15) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(13)~~ (16) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

~~(14)~~ (17) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(15)~~ (18) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing ~~aides, orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

~~(16)~~ (20) for supervisory staff, ~~the basic wage is $17.43 per hour~~, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which ~~must be $30.75 per hour~~ is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

~~(17)~~ (21) for registered nurse staff, ~~the basic wage is $30.82 per hour~~, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

~~(18)~~ (22) for licensed practical nurse staff, ~~the basic wage is $18.64 per hour~~ 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

~~(16)~~ (19) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists, which must be $30.75 per hour;

~~(17)~~ (20) for registered nurse, the basic wage is $30.82 per hour; and

~~(18)~~ (21) for licensed practical nurse staff, ~~the basic wage is $18.64 per hour~~ 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

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(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: ~~3.1~~ 15.5 percent;

(5) client programming and supports ratio: ~~8.6~~ 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

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(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: ~~3.9~~ 5.9 percent.

(e) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: ~~3.1~~ 15.5 percent;

(5) client programming and supports ratio: ~~8.6~~ 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

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(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: ~~3.1~~ 7.0 percent;

(5) client programming and support ratio: ~~8.6~~ 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on the most recently available wage data by SOC from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher

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(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: ~~3.1~~ 7.0 percent;

(5) client programming and support ratio: ~~8.6~~ 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: ~~6.1~~ 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on December 31 of the calendar year five years prior.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on the most recently available wage data by standard occupational code (SOC) from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher

or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the date of the data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) If Bureau of Labor Statistics SOC or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(k) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit business cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Required business cost data includes, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. ~~This adjustment occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.~~ On January 1, 2022, and every two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from the date of the previous update to the date of the data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(k) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit business cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Required business cost data includes, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

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(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(l) A provider must submit cost component data at least once in any five-year period, on a schedule determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost component data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(m) The commissioner shall conduct a random audit of data submitted under paragraph (k) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (k) and provide recommendations for adjustments to cost components.

(n) The commissioner shall analyze cost documentation in paragraph (k) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release business cost data in an aggregate form, and business cost data from individual providers shall not be released except as provided for in current law.

(o) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (k).

EFFECTIVE DATE. (a) The amendments to paragraphs (a) to (g) are effective January 1, 2018, except the amendment to paragraph (d), clause (8), which is effective January 1, 2019, and the amendment to paragraph (a), clause (10), which is effective the day following final enactment.

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(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(l) A provider must submit cost component data at least once in any five-year period, on a schedule determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost component data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(m) The commissioner shall conduct a random audit of data submitted under paragraph (k) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (k) and provide recommendations for adjustments to cost components.

(n) The commissioner shall analyze cost documentation in paragraph (k) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release business cost data in an aggregate form, and business cost data from individual providers shall not be released except as provided for in current law.

(o) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (k).

EFFECTIVE DATE. (a) The amendments to paragraphs (a) to (g) are effective January 1, 2018, except paragraph (d), clause (8), is effective January 1, 2019.

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(b) The amendments to paragraphs (h) to (o) are effective the day following final enactment.

Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

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(b) The amendments to paragraphs (h) to (o) are effective the day following final enactment.

Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. ~~If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.~~

(e) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

(f) Beginning January 1, 2018, for foster care and supportive living services provided in a corporate setting with rates calculated under this section, the number of days authorized must not exceed 350 days in an annual service span.

Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.

(e) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

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(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

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(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

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Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, and ~~supported~~ employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

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Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, independent living skills specialist services, hourly supported living services, employment exploration services, employment development services, and ~~supported~~ employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for ~~supported~~ employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed ~~three~~ six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for ~~supported~~ employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed ~~three~~ six. For independent living skills training provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause ~~(16)~~ (19);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

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(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.

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(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.

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(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates ~~for day services~~;

~~(2) values for transportation rates in residential services;~~

~~(3)~~ (2) values for services where monitoring technology replaces staff time;

~~(4)~~ (3) values for indirect services;

~~(5)~~ (4) values for nursing;

~~(6) component values for independent living skills;~~

~~(7) component values for family foster care that reflect licensing requirements;~~

~~(8) adjustments to other components to replace the budget neutrality factor;~~

~~(9) remote monitoring technology for nonresidential services;~~

~~(10) values for basic and intensive services in residential services;~~

~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

~~(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and~~

~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying cost of providing home and community-based services~~.~~; and

(9) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

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(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates ~~for day services~~;

~~(2) values for transportation rates in residential services;~~

~~(3)~~ (2) values for services where monitoring technology replaces staff time;

~~(4)~~ (3) values for indirect services;

~~(5)~~ (4) values for nursing;

~~(6) component values for independent living skills;~~

~~(7) component values for family foster care that reflect licensing requirements;~~

~~(8) adjustments to other components to replace the budget neutrality factor;~~

~~(9) remote monitoring technology for nonresidential services;~~

~~(10) values for basic and intensive services in residential services;~~

~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

~~(14) a component value to reflect costs for individuals with rates previously adjusted for the inclusion of group residential housing rate 3 costs, only for any individual enrolled as of December 31, 2013; and~~

~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying cost of providing home and community-based services~~.~~; and

(9) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, ~~2019~~ 2020, with another full report, and a full report once every four years thereafter.

~~(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by January 15, 2015, to address any issues identified during the first year of implementation. After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.~~

~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the commissioner shall renew analysis and implement changes to the regional adjustment factors when adjustments required under subdivision 5, paragraph (h), occur. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(h)~~ (g) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d) on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, ~~2019~~ 2020, with another full report, and a full report once every four years thereafter.

~~(f) Based on the commissioner's evaluation of the information and data collected in paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by January 15, 2015, to address any issues identified during the first year of implementation. After January 15, 2015, the commissioner may make recommendations to the legislature to address potential issues.~~

~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the commissioner shall renew analysis and implement changes to the regional adjustment factors when adjustments required under subdivision 5, paragraph (h), occur. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(h)~~ (g) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

~~(i) No later than July 1, 2016, the commissioner shall develop and implement, in consultation with stakeholders, a methodology sufficient to determine the shared staffing levels necessary to meet, at a minimum, health and welfare needs of individuals who will be living together in shared residential settings, and the required shared staffing activities described in subdivision 2, paragraph (l). This determination methodology must ensure staffing levels are adaptable to meet the needs and desired outcomes for current and prospective residents in shared residential settings.~~

~~(j)~~ (h) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.

(j) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

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

Sec. 28. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

(c) A service rate developed using values in subdivision 5, paragraph (a), clause (10), is not subject to budget neutrality adjustments.

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

Sec. 29. Minnesota Statutes 2016, section 256B.85, subdivision 3, is amended to read:

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

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

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

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

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

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

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on an initial assessment under section 256B.0911, subdivision 3a, a reassessment under section 256B.0911, subdivision 3g, or an annual service update under section 256B.0911, subdivision 3f; and

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

Sec. 30. Minnesota Statutes 2016, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The initial 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 within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

(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. Participants approved for a temporary authorization shall access the consultation service to complete their orientation and selection of a service model.

Sec. 31. Minnesota Statutes 2016, 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 256B.0915, subdivision 6. 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~~ as necessary 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 or the participant's representative.

(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 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. 32. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 1a. **Culturally affirmative.** "Culturally affirmative" describes services that are designed and delivered within the context of the culture, language, and life experiences of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.

Sec. 33. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

Subd. 2. **Deaf.** "Deaf" means a hearing loss of such severity that the individual must depend primarily on visual communication such as American Sign Language, or other signed language, visual, and manual means of communication such as signing systems in English or cued speech, writing, ~~lip~~ speech reading, ~~manual communication,~~ and gestures.

Sec. 30. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 1a. **Culturally affirmative.** "Culturally affirmative" describes services that are designed and delivered within the context of the culture, language, and life experiences of a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.

Sec. 31. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

Subd. 2. **Deaf.** "Deaf" means a hearing loss of such severity that the individual must depend primarily on visual communication such as American Sign Language or other signed language, visual and manual means of communication such as signing systems in English or Cued Speech, writing, ~~lip~~ speech reading, ~~manual communication,~~ and gestures.

Sec. 34. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

(1) interpreting between a spoken language, such as English, and a visual language, such as American Sign Language;

(2) interpreting between a spoken language and a visual representation of a spoken language, such as cued speech and signing systems in English;

(3) interpreting within one language where the interpreter uses natural gestures and silently repeats the spoken message, replacing some words or phrases to give higher visibility on the lips;

(4) interpreting using low vision or tactile methods for people who have a combined hearing and vision loss or are deafblind; and

(5) interpreting between one communication mode or language into another communication mode or language that is linguistically and culturally appropriate for the participants in the communication exchange.

Sec. 35. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning in which a caption is simultaneously prepared and displayed or transmitted at the time of origination by specially trained real-time captioners.

Sec. 36. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The commissioners of ~~human services,~~ education, employment and economic development, and health shall ~~create a distinct and separate organizational unit to be known as~~ advise the commissioner of human services on the activities of the Deaf and Hard-of-Hearing Services Division ~~to address~~. This division addresses the developmental~~, social, educational, and occupational~~ and social-emotional needs of persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ through a statewide network of ~~collaborative~~ services and ~~by coordinating the promulgation of public policies, regulations, legislation, and programs affecting~~ advocates on behalf of and provides information and training about how to best serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons. An interdepartmental management team shall advise the activities of the Deaf and~~

Sec. 32. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision to read:

Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

(1) interpreting between a spoken language, such as English, and a visual language, such as American Sign Language;

(2) interpreting between a spoken language and a visual representation of a spoken language, such as Cued Speech and signing systems in English;

(3) interpreting within one language where the interpreter uses natural gestures and silently repeats the spoken message, replacing some words or phrases to give higher visibility on the lips;

(4) interpreting using low vision or tactile methods for persons who have a combined hearing and vision loss or are deafblind; and

(5) interpreting from one communication mode or language into another communication mode or language that is linguistically and culturally appropriate for the participants in the communication exchange.

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Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning in which a caption is simultaneously prepared and displayed or transmitted at the time of origination by specially trained real-time captioners.

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~~Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate the work of the interagency ~~management team~~ advisers and receive legislative appropriations for the division.

Sec. 37. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** The Deaf and Hard-of-Hearing Services Division shall:

(1) establish and maintain a statewide network of regional ~~service centers~~ culturally affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing ~~Minnesotans~~;

(2) ~~assist~~ work across divisions within the ~~Departments~~ Department of Human Services, ~~Education, and Employment and Economic Development to coordinate the promulgation and implementation of public policies, regulations, legislation, programs, and services affecting~~ as well as with other agencies and counties, to ensure that there is an understanding of:

(i) the communication challenges faced by persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

(ii) the best practices for accommodating and mitigating communication challenges; and

(iii) the legal requirements for providing access to and effective communication with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; ~~and~~

(3) ~~provide a coordinated system of~~ assess the supply and demand statewide ~~interpreting or~~ for interpreter ~~referral~~ services~~.~~ and real-time captioning services, implement strategies to provide greater access to these services in areas without sufficient supply, and build the base of service providers across the state;

(4) maintain a statewide information resource that includes contact information and professional certification credentials of interpreting service providers and real-time captioning service providers;

(5) provide culturally affirmative mental health services to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind, who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

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~~Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate the work of the interagency ~~management team~~ advisers and receive legislative appropriations for the division.

Sec. 35. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** The Deaf and Hard-of-Hearing Services Division shall:

(1) establish and maintain a statewide network of regional ~~service centers~~ culturally affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and Minnesotans who are hard-of-hearing ~~Minnesotans~~;

(2) ~~assist~~ work across divisions within the ~~Departments~~ Department of Human Services, ~~Education, and Employment and Economic Development to coordinate the promulgation and implementation of public policies, regulations, legislation, programs, and services affecting~~ as well as with other agencies and counties, to ensure that there is an understanding of:

(i) the communication challenges faced by persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

(ii) the best practices for accommodating and mitigating communication challenges; and

(iii) the legal requirements for providing access to and effective communication with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; ~~and~~

(3) ~~provide a coordinated system of~~ assess the supply and demand statewide ~~interpreting or~~ for interpreter ~~referral~~ services~~.~~ and real-time captioning services, implement strategies to provide greater access to these services in areas without sufficient supply, and build the base of service providers across the state;

(4) maintain a statewide information resource that includes contact information and professional certification credentials of interpreting service providers and real-time captioning service providers;

(5) provide culturally affirmative mental health services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

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(ii) otherwise need culturally affirmative therapeutic services;

(6) research and develop best practices and recommendations for emerging issues;

(7) provide as much information as practicable on the division's stand-alone Web site in American Sign Language; and

(8) report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services biennially, beginning on January 1, 2019, on the following:

(i) the number of regional service center staff, the location of the office of each staff person, other service providers with which they are colocated, the number of people served by each staff person, and a breakdown of whether each person was served on-site or off-site, and for those served off-site, a list of locations where services were delivered, and the number who were served in-person and the number who were served via technology;

(ii) the amount and percentage of the division budget spent on reasonable accommodations for staff;

(iii) the number of people who use demonstration equipment and consumer evaluations of the experience;

(iv) the number of training sessions provided by division staff, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(v) the number of training sessions hosted at a division location provided by another service provider, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(vi) for each grant awarded, the amount awarded to the grantee and a summary of the grantee's results, including consumer evaluations of the services or products provided;

(vii) the number of people on waiting lists for any services provided by division staff or for services or equipment funded through grants awarded by the division;

(viii) the amount of time staff spent driving to appointments to deliver direct one-to-one client services in locations outside of the regional service centers;

(ix) the amount spent on mileage reimbursement and the number of clients who received mileage reimbursement for traveling to the regional service centers for services; and

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(ii) otherwise need culturally affirmative therapeutic services;

(6) research and develop best practices and recommendations for emerging issues;

(7) provide as much information as practicable on the division's stand-alone Web site in American Sign Language; and

(8) report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services biennially, beginning on January 1, 2019, on the following:

(i) the number of regional service center staff, the location of the office of each staff person, other service providers with which they are colocated, the number of people served by each staff person and a breakdown of whether each person was served on-site or off-site, and for those served off-site, a list of locations where services were delivered and the number who were served in-person and the number who were served via technology;

(ii) the amount and percentage of the division budget spent on reasonable accommodations for staff;

(iii) the number of people who use demonstration equipment and consumer evaluations of the experience;

(iv) the number of training sessions provided by division staff, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(v) the number of training sessions hosted at a division location provided by another service provider, the topics covered, the number of participants, and consumer evaluations, including a breakdown by delivery method such as in-person or via technology;

(vi) for each grant awarded, the amount awarded to the grantee and a summary of the grantee's results, including consumer evaluations of the services or products provided;

(vii) the number of people on waiting lists for any services provided by division staff or for services or equipment funded through grants awarded by the division;

(viii) the amount of time staff spent driving to appointments to deliver direct one-to-one client services in locations outside of the regional service centers;

(ix) the amount spent on mileage reimbursement and the number of clients who received mileage reimbursement for traveling to the regional service centers for services; and

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(x) the regional needs and feedback on addressing service gaps identified by the advisory committee.

Sec. 38. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish ~~up to eight~~ at least six regional service centers for persons who are deaf and persons who are hard-of-hearing ~~persons~~. The centers shall be distributed regionally to provide access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state.

Sec. 39. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** Each regional service center shall:

(1) ~~serve as a central entry point for~~ establish connections and collaborations colocating with other public and private entities providing services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons in need of services and make referrals to the services needed~~ in the region;

(2) for those in need of services, assist in coordinating services between service providers and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and make referrals to the services needed;

~~(2)~~ (3) employ staff trained to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

~~(3)~~ (4) if adequate services are not available from another public or private service provider in the region, provide ~~to all~~ individual assistance to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons access to interpreter services which are necessary to help them obtain services~~, and the persons' families. Individual culturally affirmative assistance may be provided using technology only in areas of the state when a person has access to sufficient quality telecommunications or broadband services to allow effective communication. When a person who is deaf, a person who is deafblind, or a person who is hard-of-hearing does not have access to sufficient telecommunications or broadband service, individual assistance shall be available in person;

(5) identify regional training needs, work with deaf and hard-of-hearing services training staff, and collaborate with others to deliver training for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and other

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(x) the regional needs and feedback on addressing service gaps identified by the advisory committees.

Sec. 36. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish ~~up to eight~~ at least six regional service centers for persons who are deaf and persons who are hard-of-hearing ~~persons~~. The centers shall be distributed regionally to provide access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state.

Sec. 37. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

Subd. 2. **Responsibilities.** (a) Each regional service center shall:

(1) ~~serve as a central entry point for~~ establish connections and collaborations and explore co-locating with other public and private entities providing services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons in need of services and make referrals to the services needed~~ in the region;

(2) for those in need of services, assist in coordinating services between service providers and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and make referrals to the services needed;

~~(2)~~ (3) employ staff trained to work with persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~;

~~(3)~~ (4) if adequate services are not available from another public or private service provider in the region, provide ~~to all~~ individual assistance to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons access to interpreter services which are necessary to help them obtain services~~, and the persons' families. Individually culturally affirmative assistance may be provided using technology only in areas of the state where a person has access to sufficient quality telecommunications or broadband services to allow effective communication. When a person who is deaf, a person who is deafblind, or a person who is hard-of-hearing does not have access to sufficient telecommunications or broadband service, individual assistance shall be available in person;

(5) identify regional training needs, work with deaf and hard-of-hearing services training staff, and collaborate with others to deliver training for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' families, and other

service providers about subjects including the persons' rights under the law, American Sign Language, and the impact of hearing loss and options for accommodating it;

~~(4) implement a plan to provide loaned equipment and resource materials to deaf, deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection of modern assistive technology and equipment to determine what would best meet the persons' needs;

~~(5) cooperate with responsible departments and administrative authorities to provide access for deaf, deafblind, and hard-of-hearing persons to services provided by state, county, and regional agencies;~~

~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons, other divisions of the Department of Education~~,~~ and local school districts to develop and deliver programs and services for families with children who are deaf, children who are deafblind, or children who are hard-of-hearing ~~children~~ and to support school personnel serving these children;

~~(7) when possible,~~ (8) provide training to the social service or income maintenance staff employed by counties or by organizations with whom counties contract for services to ensure that communication barriers which prevent persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ from using services are removed;

~~(8) when possible,~~ (9) provide training to ~~state and regional~~ human service agencies in the region regarding program access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~; ~~and~~

~~(9)~~ (10) assess the ongoing need and supply of services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state, annually consult with the division's advisory committees to identify regional needs and solicit feedback on addressing service gaps, and cooperate with public and private service providers to develop these services~~.~~;

(11) provide culturally affirmative mental health services to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind, who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

(ii) otherwise need culturally affirmative therapeutic services; and

service providers about subjects including the persons' rights under the law, American Sign Language, and the impact of hearing loss and options for accommodating it;

~~(4) implement a plan to provide loaned equipment and resource materials to deaf, deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection of modern assistive technology and equipment to determine what would best meet the persons' needs;

~~(5) cooperate with responsible departments and administrative authorities to provide access for deaf, deafblind, and hard-of-hearing persons to services provided by state, county, and regional agencies;~~

~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons, other divisions of the Department of Education~~,~~ and local school districts to develop and deliver programs and services for families with children who are deaf, children who are deafblind, or children who are hard-of-hearing ~~children~~ and to support school personnel serving these children;

~~(7) when possible,~~ (8) provide training to the social service or income maintenance staff employed by counties or by organizations with whom counties contract for services to ensure that communication barriers which prevent persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ from using services are removed;

~~(8) when possible,~~ (9) provide training to ~~state and regional~~ human service agencies in the region regarding program access for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~; ~~and~~

~~(9)~~ (10) assess the ongoing need and supply of services for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing ~~persons~~ in all parts of the state, annually consult with the division's advisory committees to identify regional needs and solicit feedback on addressing service gaps, and cooperate with public and private service providers to develop these services~~.~~;

(11) provide culturally affirmative mental health services to persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing who:

(i) use a visual language such as American Sign Language or a tactile form of a language; or

(ii) otherwise need culturally affirmative therapeutic services; and

(12) establish partnerships with state and regional entities statewide with the technological capacity to provide Minnesotans with virtual access to the division's services and division-sponsored training via technology.

(12) establish partnerships with state and regional entities statewide that have the technological capacity to provide Minnesotans with virtual access to the division's services and division-sponsored training via technology.

(b) Persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the persons' family members who travel more than 50 miles round-trip from the persons' home or work location to receive services at the regional service center may be reimbursed for mileage at the reimbursement rate established by the Internal Revenue Service.

Sec. 40. Minnesota Statutes 2016, section 256C.24, is amended by adding a subdivision to read:

Subd. 4. **Transportation cost reimbursement.** Persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing, and the person's family members who travel more than 50 miles round-trip from the person's home or work location to receive services at the regional service center may be reimbursed by the Deaf and Hard-of-Hearing Division for mileage at the reimbursement rate established by the Internal Revenue Service.

Sec. 41. Minnesota Statutes 2016, section 256C.261, is amended to read:

Sec. 38. Minnesota Statutes 2016, section 256C.261, is amended to read:

256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND ~~PERSONS~~.

256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND ~~PERSONS~~.

(a) The commissioner of human services shall ~~combine the existing biennial base level funding for deafblind services into a single grant program. At least 35 percent of the total funding is awarded for services and other supports to deafblind children and their families and at least 25 percent is awarded for services and other supports to deafblind adults~~ use at least 35 percent of the deafblind services biennial base level grant funding for services and other supports for a child who is deafblind and the child's family. The commissioner shall use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.

(a) The commissioner of human services shall ~~combine the existing biennial base level funding for deafblind services into a single grant program. At least 35 percent of the total funding is awarded for services and other supports to deafblind children and their families and at least 25 percent is awarded for services and other supports to deafblind adults.~~ use at least 35 percent of the deafblind services biennial base level grant funding for services and other supports for a child who is deafblind and the child's family. The commissioner shall use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.

The commissioner shall award grants for the purposes of:

The commissioner shall award grants for the purposes of:

(1) providing services and supports to ~~individuals~~ persons who are deafblind; and

(1) providing services and supports to ~~individuals~~ persons who are deafblind; and

(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible persons who are deafblind ~~persons~~ and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.

(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible persons who are deafblind ~~persons~~ and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.

(b) The commissioner may make grants:

(b) The commissioner may make grants:

(1) for services and training provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Consumer-directed services shall be provided in whole by grant-funded providers. The deaf and hard-of-hearing regional service centers shall not provide any aspect of a grant-funded consumer-directed services program.

~~(c)~~ (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

~~(d)~~ (e) Deafblind service providers may, but are not required to, provide intervenor services as part of the service package provided with grant funds under this section.

Sec. 43. **FEDERAL WAIVER REQUESTS.**

The commissioner of human services shall submit necessary waiver amendments to the Centers for Medicare and Medicaid Services to add employment exploration services, employment development services, and employment support services to the home and community-based services waiver authorized under Minnesota Statutes, sections 256B.092 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove community-based employment from day training and habilitation and prevocational services. The commissioner shall submit the necessary waiver amendments by October 1, 2017.

EFFECTIVE DATE. This section is effective August 1, 2017.

Sec. 42. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS.**

(a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(1) for services and training provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Consumer-directed services shall be provided in whole by grant-funded providers. The deaf and hard-of-hearing regional service centers shall not provide any aspect of a grant-funded consumer-directed services program.

~~(c)~~ (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

~~(d)~~ (e) Deafblind service providers may, but are not required to, provide intervenor services as part of the service package provided with grant funds under this section.

Sec. 68. **FEDERAL WAIVER AMENDMENTS.**

The commissioner of human services shall submit necessary waiver amendments to the Centers for Medicare and Medicaid Services to add employment exploration services, employment development services, and employment support services to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove community-based employment services from day training and habilitation and prevocational services. The commissioner shall submit all necessary waiver amendments by October 1, 2017.

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

Sec. 69. **EXCEPTION TO THE BUDGET METHODOLOGY FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS.**

(a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process as described in the home and community-based services waivers under sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; or

(2) requires services that are more expensive than appropriate less-restrictive services using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget exception shall be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

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

Sec. 44. **TRANSPORTATION STUDY.**

The commissioner of human services, with cooperation from lead agencies and in consultation with stakeholders, shall conduct a study to identify opportunities to increase access to transportation services for an individual who receives home and community-based services. The commissioner shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2019. The report shall:

(1) study all aspects of the current transportation service network, including the fleet available, the different rate-setting methods currently used, methods that an individual uses to access transportation, and the diversity of available provider agencies;

(2) identify current barriers for an individual accessing transportation and for a provider providing waiver services transportation in the marketplace;

(3) identify efficiencies and collaboration opportunities to increase available transportation, including transportation funded by medical assistance, and available regional transportation and transit options;

(4) study transportation solutions in other states for delivering home and community-based services;

(5) study provider costs required to administer transportation services;

(6) make recommendations for coordinating and increasing transportation accessibility across the state; and

(7) make recommendations for the rate setting of waivered transportation.

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

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities, nursing facilities, acute care hospitals, Anoka Metro Regional Treatment Center, Minnesota Security Hospital, and crisis beds. The budget exception shall be limited to no more than the amount of appropriate less-restrictive available services determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

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

Sec. 66. **TRANSPORTATION STUDY.**

The commissioner of human services, with cooperation from lead agencies and in consultation with stakeholders, shall conduct a study to identify opportunities to increase access to transportation services for an individual who receives home and community-based services. The commissioner shall submit a report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15, 2019. The report shall:

(1) study all aspects of the current transportation service network, including the fleet available, the different rate-setting methods currently used, methods that an individual uses to access transportation, and the diversity of available provider agencies;

(2) identify current barriers for an individual accessing transportation and for a provider providing waiver services transportation in the marketplace;

(3) identify efficiencies and collaboration opportunities to increase available transportation, including transportation funded by medical assistance, and available regional transportation and transit options;

(4) study transportation solutions in other states for delivering home and community-based services;

(5) study provider costs required to administer transportation services;

(6) make recommendations for coordinating and increasing transportation accessibility across the state; and

(7) make recommendations for the rate setting of waivered transportation.

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

Senate Language S0800-3

Sec. 45. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION EQUIPMENT PROGRAM.**

(a) The commissioner of human services shall work in consultation with the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by January 15, 2018, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over human services to modernize the telecommunication equipment program. The recommendations must address:

(1) types of equipment and supports the program should provide to ensure people with communication difficulties have equitable access to telecommunications services;

(2) additional services the program should provide such as education about technology options that can improve a person's access to telecommunications service; and

(3) how the current program's service delivery structure might be improved to better meet the needs of people with communication disabilities.

(b) The commissioner shall also provide draft legislative language to accomplish the recommendations. Final recommendations, the final report, and draft legislative language must be approved by both the commissioner and the chair of the commission.

Sec. 46. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH SERVICES.**

By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

Sec. 47. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES.**

The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services under Minnesota Statutes, section 256B.0911, to modify the MnCHOICES assessment tool and related policies to:

(1) reduce assessment times;

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Sec. 63. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION EQUIPMENT PROGRAM.**

The commissioner of human services shall work in consultation with the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by January 15, 2018, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over human services to modernize the telecommunication equipment program. The recommendations must address:

(1) types of equipment and supports the program should provide to ensure people with communication difficulties have equitable access to telecommunications services;

(2) additional services the program should provide, such as education about technology options that can improve a person's access to telecommunications services; and

(3) how the current program's service delivery structure might be improved to better meet the needs of people with communication disabilities.

The commissioner shall also provide draft legislative language to accomplish the recommendations. Final recommendations, the final report, and draft legislative language must be approved by both the commissioner and the chair of the Commission of Deaf, Deafblind, and Hard-of-Hearing Minnesotans.

Sec. 64. **DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH SERVICES.**

By January 1, 2018, the commissioner of human services shall report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health services.

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(2) create efficiencies within the tool and within practice and policy for conducting assessments and support planning;

(3) implement policy changes reducing the frequency and depth of assessment and reassessment, while ensuring federal compliance with medical assistance and disability waiver eligibility requirements; and

(4) evaluate alternative payment methods.

Sec. 48. **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 increase consumer-directed community support budgets up to 30 percent for the following:

(1) consumer-directed community support participants whose current consumer-directed community support budget cannot accommodate increased services and supports identified in the participant's coordinated service and support plan and that are required in order to:

(i) increase the amount of time a participant works or otherwise improves employment opportunity;

(ii) 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); or

(iii) develop and implement a positive support plan; or

(2) home and community-based waiver participants who are currently using licensed providers for residential services that cost more annually than the participant would spend under a consumer-directed community support plan for any and all of the services and supports needed to meet the goals identified in clause (1).

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Sec. 60. Laws 2015, chapter 71, article 7, section 54, is amended to read:

Sec. 54. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, ~~2015~~ 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 ~~establish an~~ expand the 2015 exception to the consumer-directed community supports budget methodology to provide up to ~~20~~ 30 percent more funds for both:

(1) consumer-directed community supports participants who ~~have graduated from high school and~~ have a coordinated service and support plan which identifies the need for ~~more services under consumer-directed community supports, either prior to graduation or in order to increase the amount of time a person works or to improve their employment opportunities,~~ an increased amount of services or supports under consumer-directed community supports than the amount they are ~~eligible to receive~~ currently receiving under the ~~current~~ consumer-directed community supports budget methodology~~; and~~:

(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 as described in Minnesota Statutes, section 256D.44, subdivision 5, paragraph (f), clause (1), item (ii), or (g); or

(iii) to develop and implement a positive behavior support plan;

(2) home and community-based waiver participants who are currently using licensed ~~services~~ providers for employment supports or services during the day or residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for ~~individualized employment supports or services during the day~~ any or all of the supports needed to meet the goals identified in paragraph (a), clause (1).

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(b) The exception under paragraph (a), clause (1), is limited to those consumer-directed community participants who can demonstrate that the participant shall discontinue consumer-directed community supports and accept other nonself-directed waiver services because the participant cannot meet the goals described in paragraph (a), clause (1), within the participant's current consumer-directed community support budget limits.

(c) The exception under paragraph (a), clause (2), is limited to those home and community-based waiver participants who can demonstrate that, upon choosing to become a consumer-directed community support participant, the total cost of services, including the exception, would be less than the cost of the waiver services the participant would otherwise receive.

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(b) The exception under paragraph (a) is limited to those persons who can demonstrate either that they will have to ~~leave~~ discontinue using consumer-directed community supports and ~~use~~ accept other non-self-directed waiver services because their ~~need for day or employment~~ supports needed for the goals described in paragraph (a), clause (1), cannot be met within the consumer-directed community supports budget limits ~~or they will move to consumer-directed community supports and their services will cost less than services currently being used~~.

(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 support participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

EFFECTIVE DATE. The exception under this section is effective October 1, 2017, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 62. **CONSUMER-DIRECTED COMMUNITY SUPPORTS REVISED BUDGET METHODOLOGY REPORT.**

(a) The commissioner of human services, in consultation with stakeholders and others including representatives of lead agencies, home and community-based services waiver participants using consumer-directed community supports, advocacy groups, state agencies, the Institute on Community Integration at the University of Minnesota, and service and financial management providers, shall develop a revised consumer-directed community supports budget methodology. The new methodology shall be based on (1) the costs of providing services as reflected by the wage and other relevant components incorporated in the disability waiver rate formulas under chapter 256B, and (2) state-to-county waiver-funding methodologies. The new methodology should develop individual consumer-directed community supports budgets comparable to those provided for similar needs individuals if paying for non-consumer-directed community supports waiver services.

(b) By December 15, 2018, the commissioner shall report a revised consumer-directed community supports budget methodology, including proposed legislation and funding necessary to implement the new methodology, to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services.

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

Senate Language S0800-3

Sec. 49. **REPEALER.**

(a) Minnesota Statutes 2016, sections 256C.23, subdivision 3; 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed effective the day following final enactment.

(b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective January 1, 2018.

House Language UES0800-2

Sec. 70. **REPEALER.**

(a) Minnesota Statutes 2016, sections 256C.23, subdivision 3; 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed.

(b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective January 1, 2018.