..... moves to amend H.F. No. 1225 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2018, section 256B.0659, subdivision 1, is amended to read:

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

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

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

(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.

(h) "Enhanced rate" means personal care assistance services provided to a recipient who qualifies for ten or more hours per day of personal care assistance services by a personal care assistant who satisfies the requirements of subdivision 11, paragraph (d).

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

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

(n) "Qualified professional service" means supervision of personal care assistance services and personal care assistants provided by a qualified professional under section 256B.0625, subdivision 19c.

~~(l)~~ (o) "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~~ comprehensive home care licensed agency, and Medicare-certified home health agency.

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

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

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

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

~~(r)~~ (u) "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 January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 2. Minnesota Statutes 2018, 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~~ 310 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) To qualify for the enhanced rate, personal care assistance services must be provided by personal care assistants who satisfy the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 3. Minnesota Statutes 2018, 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 personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the

agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 4. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

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

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

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

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

(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

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

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

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

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

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

(15) document that the additional revenue the agency receives for the enhanced rate is passed on, in wages and benefits, to the personal care assistant who provided services to a recipient who is eligible for the enhanced rate.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 5. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), if personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under this section;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when approval is obtained.

Sec. 6. **[256B.0715] DIRECT CARE WORKFORCE REPORT.**

The commissioner of human services shall annually assess the direct care workforce and publish findings in a direct care workforce report each August beginning August 1, 2020. This report shall consider the number of workers employed, the number of regular hours worked, the number of overtime hours worked, the regular wages and benefits paid, the overtime wages paid, retention rates, and job vacancies across providers of home and community-based services disability waiver services, state plan home care services, state plan personal care assistance services, and community first services and supports.

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

Sec. 7. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal

year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

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

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

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

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

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

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate

increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

(f) The commissioner shall approve an exception to the monthly case mix budget cap in paragraph (a) to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659. The commissioner shall calculate the difference between the rate for personal care assistance services and the enhanced rate. The additional budget amount approved under an exception shall not exceed this difference.

EFFECTIVE DATE. Paragraph (f) is effective July 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2018, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and

providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans:

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.; and

(2) by January 30 of each year in which a rate increase occurs for any aspect of personal care assistance services, the enhanced rate, and qualified professional services under section 256B.0659, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over personal care assistance service rates of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract.

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

managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

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

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

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar

year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

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

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

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

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

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

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

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

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

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Sec. 9. Minnesota Statutes 2018, section 256B.85, subdivision 2, is amended to read:

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

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

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

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

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

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

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

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

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

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

(l) "Enhanced rate" means community first services and supports provided to a participant who qualifies for ten or more hours per day of community first services and supports by a support worker who satisfies the requirements of subdivision 16, paragraph (e).

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

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

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

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

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

~~(q)~~ (r) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but

are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE; APPLICATION. This section is effective September 1, 2020, or upon federal approval, whichever is later, and applies to reassessments, reauthorizations,

and service renewals that occur on or after that date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a) Agency-providers identified in subdivision 11 and FMS providers identified in subdivision 13a shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws and policies for CFSS as determined by the commissioner;

(3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

(4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers;

(5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider; and

(9) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS providers shall:

(1) pay support workers based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

(3) withhold and pay all applicable federal and state payroll taxes;

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

(5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided;

(6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

(7) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13; and

(8) maintain documentation for the requirements under subdivision 16, paragraph (e), clause (2), to qualify CFSS services for an enhanced rate.

EFFECTIVE DATE; APPLICATION. This section is effective September 1, 2020, or upon federal approval, whichever is later, and applies to reassessments, reauthorizations, and service renewals that occur on or after that date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2018, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS 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. CFSS support worker 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 support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 275 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS services qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS services in subdivision 7, to a participant who qualifies for ten or more hours per day of CFSS services; and

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

EFFECTIVE DATE; APPLICATION. This section is effective September 1, 2020, or upon federal approval, whichever is later, and applies to reassessments, reauthorizations, and service renewals that occur on or after that date. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. **[256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS PAYMENT METHODOLOGY.**

Subdivision 1. **Application generally.** The payment methodologies in this section apply to:

(1) personal care assistance services, extended personal care assistance services, the enhanced rate, and qualified professional services under section 256B.0659; and

(2) community first services and supports, extended CFSS, enhanced rate CFSS, and CFSS worker training and development under section 256B.85.

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

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

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

Subd. 3. **Payment rates; base wage index.** (a) When initially establishing the base wage component values, the commissioner shall use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the most recent edition of the Occupational Handbook. The commissioner shall calculate the base wage component values as follows:

(1) for personal care assistance services, community first services and supports, extended personal care assistance services, and extended CFSS, the base wage component value shall be the median wage for personal care aide (SOC code 39-9021);

(2) for enhanced rate personal care assistance services and enhanced rate CFSS, the base wage component value shall be the sum of 50 percent of the median wage for personal care aide (SOC code 39-9021) and 50 percent of the median wage for home health aide (SOC code 31-1011); and

(3) for qualified professional services and CFSS worker training and development, the base wage component value shall be the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1022), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

(b) On January 1, 2022, and every two years thereafter, the commissioner shall update the base wage component values in paragraph (a) based on the wage data by SOC codes from the Bureau of Labor Statistics available one year and a day prior to the scheduled update. The commissioner shall publish the updated base wage component values.

Subd. 4. **Payment rates; total wage index.** (a) The commissioner shall multiply the base wage component values in subdivision 3 by one plus the competitive workforce factor. The product is the total wage component value.

(b) For personal care assistance services, community first services and supports, extended personal care assistance services, and extended CFSS, the initial competitive workforce factor is eight-tenths of one percent.

(c) For enhanced rate personal care assistance services and enhanced rate CFSS, the initial competitive workforce factor is zero percent.

(d) For qualified professional services and CFSS worker training and development, the competitive workforce factor is zero percent.

(e) On January 1, 2022, and January 1, 2024, the commissioner shall increase the competitive workforce factor in paragraphs (b) and (c) by three percentage points.

(f) Beginning January 1, 2026, and every two years thereafter, the commissioner shall recommend updates to the competitive workforce factor using:

(1) the most recently available wage data by standard occupational classification (SOC) code from the Bureau of Labor Statistics for the weighted average wage of direct care staff for personal care aides (SOC code 39-9021); and

(2) the most recently available wage data by SOC code from the Bureau of Labor Statistics for the weighted average wage of all other SOC codes with the same Bureau of

Labor Statistics classifications for education, experience, and training required for job competencies.

(g) The commissioner shall not recommend an increase or decrease of the competitive workforce factor from its current value by more than three percentage points. If, after the biennial analysis as described in paragraph (f), the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

Subd. 5. **Payment rates; standard component values.** The component value factors are:

(1) employee vacation, sick, and training factor: 8.71 percent;

(2) employer taxes and workers' compensation factor: 11.56 percent;

(3) employee benefits factor: 12.04 percent;

(4) client programming and supports factor: 0.0 percent;

(5) program plan support factor: 0.0 percent; and

(6) general business and administrative expenses factor: 14.40 percent.

Subd. 6. **Payment rates; total rate determination.** (a) The commissioner shall determine the total rates for personal care assistance services, community first services and supports, extended personal care assistance service, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the total wage component value determined in subdivision 4 by the employee vacation, sick, and training factor. The product is the direct staffing rate;

(2) for employee-related expenses, add the factor for employer taxes and workers' compensation and the factor for employee benefits. The sum is employee-related expenses. Multiply the total wage component value determined in subdivision 4 by the value for employee-related expenses;

(3) for program expenses, add the client programming and supports factor and the program plan support factor. The sum is program expenses. Multiply the base wage component value for services in subdivision 3, paragraph (a), clause (1), by the program expenses;

(4) for administrative expenses, multiply the base wage component value for services in subdivision 3, paragraph (a), clause (1), by the factor for general business and administrative expenses; and

(5) add the results of clauses (1) to (4) to the total wage component value determined in subdivision 4 and divide the sum by four. The quotient is the total payment rate for a 15-minute unit.

(b) The commissioner shall publish the total payment rates.

Subd. 7. **Provider agency; required reporting and analysis of cost data.** (a) The commissioner must evaluate on an ongoing basis whether the base wage component values and component values in this section appropriately address the cost to provide the service. The commissioner must make recommendations to adjust the rate methodology as indicated by the evaluation. As determined by the commissioner, in consultation with stakeholders, provider agencies enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner. Requested cost data may include, 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;

(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.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. 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 may temporarily suspend payments to the provider if

cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to component values.

(d) Beginning February 1, 2022, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance the following:

(1) an analysis of cost documentation in paragraph (a) and section 256B.0715, and submit recommended updates to the component values and base wage component values; and

(2) an analysis of the competitive workforce factor under subdivision 4, and submit recommended updates to the factor.

(e) The commissioner, in consultation with stakeholders, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

Subd. 8. **Payment rates evaluation.** (a) Notwithstanding subdivision 7, paragraph (d), the commissioner shall assess the component values used in the rate methodology in subdivision 5. The commissioner shall publish evaluation findings and recommended changes to the rate methodology in a report to the legislature on August 1, 2022.

(b) The commissioner shall assess the long-term impacts of the rate methodology implementation on personal care assistants, support workers, and qualified professionals, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention. Notwithstanding subdivision 7, paragraph (d), the commissioner shall publish evaluation findings in a report to the legislature on August 1, 2025.

(c) This subdivision expires on August 1, 2025, or upon the date the commissioner submits to the legislature the report described in paragraph (b), whichever is later. The commissioner shall inform the revisor of statutes when the report in submitted.

Subd. 9. **Payment rates; collective bargaining.** The commissioner's authority to set payment rates, including wages and benefits, for the services of individual providers as defined in section 256B.0711, subdivision 1, paragraph (d), shall be subject to the state's obligations to meet and negotiate under chapter 179A, as modified and made applicable to individual providers under section 179A.54, and to agreements with any exclusive

representative of individual providers, as authorized by chapter 179A, as modified and made applicable to individual providers under section 179A.54.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later, except for subdivision 1, clause (2), which is effective September 1, 2020, or upon federal approval, whichever is later, and applies to reassessments, reauthorizations, and service renewals that occur on or after that date. The commissioner of human services shall notify the revisor of statutes when approval is obtained."