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421.21 **ARTICLE 24**
421.22 **CONTINUING CARE**

3.1 **ARTICLE 1**
3.2 **CONTINUING CARE**

3.18 Sec. 2. Minnesota Statutes 2014, section 144A.071, subdivision 4c, is amended to read:

3.19 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The
3.20 commissioner of health, in coordination with the commissioner of human services, may
3.21 approve the renovation, replacement, upgrading, or relocation of a nursing home or
3.22 boarding care home, under the following conditions:

3.23 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
3.24 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
3.25 attached to a hospital that is also being replaced. The threshold allowed for this project
3.26 under section 144A.073 shall be the maximum amount available to pay the additional
3.27 medical assistance costs of the new facility;

3.28 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St.
3.29 Louis County, provided that the 29 beds must be transferred from active or layaway status
3.30 at an existing facility in St. Louis County that had 235 beds on April 1, 2003.

3.31 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
3.32 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
3.33 rate of the facility adding beds after completion of this project shall be the same as it was
4.1 on the day prior to the day the beds are licensed and certified. This project shall not
4.2 proceed unless it is approved and financed under the provisions of section 144A.073;

4.3 (3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of
4.4 the new beds are transferred from a 45-bed facility in Austin under common ownership
4.5 that is closed and 15 of the new beds are transferred from a 182-bed facility in Albert Lea
4.6 under common ownership; (ii) the commissioner of human services is authorized by the
4.7 2004 legislature to negotiate budget-neutral planned nursing facility closures; and (iii)
4.8 money is available from planned closures of facilities under common ownership to make
4.9 implementation of this clause budget-neutral to the state. The bed capacity of the Albert
4.10 Lea facility shall be reduced to 167 beds following the transfer. Of the 60 beds at the
4.11 new facility, 20 beds shall be used for a special care unit for persons with Alzheimer's
4.12 disease or related dementias;

4.13 (4) to license and certify up to 80 beds transferred from an existing state-owned
4.14 nursing facility in Cass County to a new facility located on the grounds of the
4.15 Ah-Gwah-Ching campus. The operating cost payment rates for the new facility shall be
4.16 determined based on the interim and settle-up payment provisions of Minnesota Rules,
4.17 part 9549.0057, and the reimbursement provisions of section 256B.431. The property
4.18 payment rate for the first three years of operation shall be $35 per day. For subsequent
4.19 years, the property payment rate of $35 per day shall be adjusted for inflation as provided
4.20 in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract
4.21 under section 256B.434;

(5) to initiate a pilot program to license and certify up to 80 beds transferred from an existing county-owned nursing facility in Steele County relocated to the site of a new acute care facility as part of the county's Communities for a Lifetime comprehensive plan to create innovative responses to the aging of its population. Upon relocation to the new site, the nursing facility shall delicense 28 beds. The ~~property~~ payment rate for ~~the first three years of operation of~~ external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (v):

(i) compute the estimated decrease in medical assistance residents served by the nursing facility by multiplying the decrease in licensed beds by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined in item (i), by the existing facility's weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the nursing facility, determined in item (i), by the average monthly elderly waiver service costs for individuals in Steele County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii); and

(v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.; and

~~For subsequent years, the adjusted property payment rate shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434; and~~

(6) to consolidate and relocate nursing facility beds to a new site in Goodhue County and to integrate these services with other community-based programs and services under a communities for a lifetime pilot program and comprehensive plan to create innovative responses to the aging of its population. ~~Eighty beds in the city of Red Wing shall be transferred from the downsizing and relocation of an existing 84-bed, hospital-owned nursing facility and the entire closure or downsizing of beds from a 65-bed nonprofit nursing facility in the community resulting in the delicensure of 69 beds in the two existing facilities~~ Two nursing facilities, one for 84 beds and one for 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding the carryforward of the approval authority in section 144A.073, subdivision 11, the funding approved in April 2009 by the commissioner of health for a project in Goodhue County shall not carry forward. The closure of the ~~69~~ 85 beds shall not be eligible for a planned closure rate adjustment under section 256B.437. The construction project permitted in this clause shall

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not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f. The ~~property~~ payment rate for ~~the first three years of operation of~~ external fixed costs for the new facility shall be increased by an amount as calculated according to items (i) to (vi):

(i) compute the estimated decrease in medical assistance residents served by both nursing facilities by multiplying the difference between the occupied beds of the two nursing facilities for the reporting year ending September 30, 2009, and the projected occupancy of the facility at 95 percent occupancy by the historical percentage of medical assistance resident days;

(ii) compute the annual savings to the medical assistance program from the delicensure by multiplying the anticipated decrease in the medical assistance residents, determined in item (i), by the hospital-owned nursing facility weighted average payment rate multiplied by 365;

(iii) compute the anticipated annual costs for community-based services by multiplying the anticipated decrease in medical assistance residents served by the facilities, determined in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue County multiplied by 12;

(iv) subtract the amount in item (iii) from the amount in item (ii);

(v) multiply the amount in item (iv) by ~~48.5~~ 57.2 percent; and

(vi) divide the difference of the amount in item (iv) and the amount in item (v) by an amount equal to the relocated nursing facility's occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance resident days.

~~For subsequent years, the adjusted property payment rate shall be adjusted for inflation as provided in section 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section 256B.434.~~

(b) Projects approved under this subdivision shall be treated in a manner equivalent to projects approved under subdivision 4a.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2017, except that the amendment to paragraph (a), clause (6), transferring the rate adjustment in items (i) to (vi) from the property payment rate to the payment rate for external fixed costs, is effective for rate years beginning on or after January 1, 2017, or upon completion of the closure and new construction authorized in paragraph (a), clause (6), whichever is later. The commissioner of human services shall notify the revisor of statutes when the section is effective.

Sec. 3. Minnesota Statutes 2014, section 144A.071, subdivision 4d, is amended to read:

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Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for consolidation of nursing facilities which includes the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256B.437, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate ~~a~~ ~~property~~ an external fixed costs rate adjustment according to clauses (1) to (3):

(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256B.437, subdivision 6;

(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and

(3) the ~~property~~ payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the later of the first day of the month following completion of the construction upgrades in the consolidation plan or the first day of the month following the complete closure of a facility designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.

(b) For purposes of calculating the net cost savings to the state, the commissioner shall consider clauses (1) to (7):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under group residential housing;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds;

(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256B.437; and

(7) the savings from not paying ~~property~~ external fixed costs payment rate adjustments from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.

(d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy percentages will be those reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

(e) To qualify for the ~~property~~ external fixed costs payment rate adjustment under this ~~provision~~ subdivision, the closing facilities shall:

(1) submit an application for closure according to section 256B.437, subdivision 3; and

(2) follow the resident relocation provisions of section 144A.161.

(f) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under section 144A.071, subdivision 3, for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

EFFECTIVE DATE. This section is effective for rate years beginning on or after January 1, 2017.

Sec. 4. Minnesota Statutes 2014, section 144A.073, subdivision 13, is amended to read:

Subd. 13. **Moratorium exception funding.** In fiscal year 2013, the commissioner of health may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

Sec. 5. Minnesota Statutes 2014, section 144A.073, subdivision 14, is amended to read:

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Subd. 14. **Moratorium exception funding.** In fiscal year 2015, the commissioner of health may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

Sec. 6. Minnesota Statutes 2014, section 144A.073, is amended by adding a subdivision to read:

Subd. 15. **Moratorium exception funding.** In fiscal year 2017, the commissioner may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $1,000,000 plus any carryover of previous appropriations for this purpose.

Sec. 7. Minnesota Statutes 2014, section 144A.611, subdivision 1, is amended to read:

Subdivision 1. **Nursing homes and certified boarding care homes.** The actual costs of tuition and textbooks and reasonable expenses for the competency evaluation or the nursing assistant training program and competency evaluation approved under section 144A.61, which are paid to nursing assistants or adult training programs pursuant to ~~subdivision~~ subdivisions 2 and 4, are a reimbursable expense for nursing homes and certified boarding care homes under ~~the provisions of chapter 256B and the rules promulgated thereunder~~ section 256B.431, subdivision 36.

Sec. 8. Minnesota Statutes 2014, section 144A.611, subdivision 2, is amended to read:

Subd. 2. ~~**Nursing assistants**~~ **Reimbursement for training program and competency evaluation costs.** A nursing assistant who has completed an approved competency evaluation or an approved training program and competency evaluation shall be reimbursed by the nursing home or certified boarding care home for actual costs of tuition and textbooks and reasonable expenses for the competency evaluation or the training program and competency evaluation 90 days after the date of employment, or upon completion of the approved training program, whichever is later.

Sec. 9. Minnesota Statutes 2014, section 144A.611, is amended by adding a subdivision to read:

Subd. 4. **Reimbursement for adult basic education components.** (a) Nursing facilities and certified boarding care homes shall provide reimbursement for costs related to additional adult basic education components of an approved nursing assistant training program, to:

(1) an adult training program that provided an approved nursing assistant training program to an employee of the nursing facility or boarding care home; or

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(2) a nursing assistant who is an employee of the nursing facility or boarding care home and completed an approved nursing assistant training program provided by an adult training program.

(b) For purposes of this subdivision, adult basic education components of a nursing assistant training program must include the following, if needed: training in mathematics, vocabulary, literacy skills, workplace skills, resume writing, and job interview skills. Reimbursement provided under this subdivision shall not exceed 30 percent of the cost of tuition, textbooks, and competency evaluation.

(c) An adult training program is prohibited from billing program students, nursing facilities, or certified boarding care homes for costs under this subdivision until the program student has been employed by the nursing facility as a certified nursing assistant for at least 90 days.

EFFECTIVE DATE. This section is effective for costs incurred on or after October 1, 2016.

Section 1. Minnesota Statutes 2014, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care Center License Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600

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421.33	125 to 149 persons	$700
421.34	150 to 174 persons	$800
421.35	175 to 199 persons	$900
422.1	200 to 224 persons	$1,000
422.2	225 or more persons	$1,100

422.3 (b)(1) A program licensed to provide one or more of the home and community-based
422.4 services and supports identified under chapter 245D to persons with disabilities or age
422.5 65 and older, shall pay an annual nonrefundable license fee based on revenues derived
422.6 from the provision of services that would require licensure under chapter 245D during the
422.7 calendar year immediately preceding the year in which the license fee is paid, according to
422.8 the following schedule:

422.9 License Holder Annual Revenue	License Fee
422.10 less than or equal to $10,000	$200
422.11 greater than $10,000 but less than or 422.12 equal to $25,000	$300
422.13 greater than $25,000 but less than or 422.14 equal to $50,000	$400

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greater than $50,000 but less than or equal to $100,000	$500
greater than $100,000 but less than or equal to $150,000	$600
greater than $150,000 but less than or equal to $200,000	$800
greater than $200,000 but less than or equal to $250,000	$1,000
greater than $250,000 but less than or equal to $300,000	$1,200
greater than $300,000 but less than or equal to $350,000	$1,400
greater than $350,000 but less than or equal to $400,000	$1,600
greater than $400,000 but less than or equal to $450,000	$1,800
greater than $450,000 but less than or equal to $500,000	$2,000

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greater than $500,000 but less than or equal to $600,000	$2,250
greater than $600,000 but less than or equal to $700,000	$2,500
greater than $700,000 but less than or equal to $800,000	$2,750
greater than $800,000 but less than or equal to $900,000	$3,000
greater than $900,000 but less than or equal to $1,000,000	$3,250
greater than $1,000,000 but less than or equal to $1,250,000	$3,500
greater than $1,250,000 but less than or equal to $1,500,000	$3,750
greater than $1,500,000 but less than or equal to $1,750,000	$4,000
greater than $1,750,000 but less than or equal to $2,000,000	$4,250

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greater than $2,000,000 but less than or equal to $2,500,000	$4,500
greater than $2,500,000 but less than or equal to $3,000,000	$4,750
greater than $3,000,000 but less than or equal to $3,500,000	$5,000
greater than $3,500,000 but less than or equal to $4,000,000	$5,500
greater than $4,000,000 but less than or equal to $4,500,000	$6,000
greater than $4,500,000 but less than or equal to $5,000,000	$6,500
greater than $5,000,000 but less than or equal to $7,500,000	$7,000
greater than $7,500,000 but less than or equal to $10,000,000	$8,500
greater than $10,000,000 but less than or equal to $12,500,000	$10,000

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greater than $12,500,000 but less than or equal to $15,000,000	$14,000
greater than $15,000,000	$18,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(5) Notwithstanding clause (1), a license holder providing services under one or more licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license fee for calendar years 2014, 2015, ~~and~~ 2016, and 2017, equal to the total license fees paid by the license holder for all licenses held under chapter 245B for calendar year 2013. For calendar year ~~2017~~ 2018 and thereafter, the license holder shall pay an annual license fee according to ~~clause (1)~~ paragraph (m).

(c) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000

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424.5	75 to 99 persons	$1,200
424.6	100 or more persons	$1,400

424.7 (d) A chemical dependency program licensed under Minnesota Rules, parts
424.8 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual
424.9 nonrefundable license fee based on the following schedule:

424.10	Licensed Capacity	License Fee
424.11	1 to 24 persons	$760
424.12	25 to 49 persons	$960
424.13	50 or more persons	$1,160

424.14 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
424.15 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on
424.16 the following schedule:

424.17	Licensed Capacity	License Fee
424.18	1 to 24 persons	$1,000
424.19	25 to 49 persons	$1,100
424.20	50 to 74 persons	$1,200

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424.21	75 to 99 persons	$1,300
424.22	100 or more persons	$1,400

424.23 (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
424.24 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
424.25 fee based on the following schedule:

424.26	Licensed Capacity	License Fee
424.27	1 to 24 persons	$2,525
424.28	25 or more persons	$2,725

424.29 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
424.30 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
424.31 license fee based on the following schedule:

424.32	Licensed Capacity	License Fee
424.33	1 to 24 persons	$450
424.34	25 to 49 persons	$650
424.35	50 to 74 persons	$850
424.36	75 to 99 persons	$1,050

424.37	100 or more persons	$1,250

425.1 (h) A program licensed to provide independent living assistance for youth under
425.2 section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

425.3 (i) A private agency licensed to provide foster care and adoption services under
425.4 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
425.5 license fee of $875.

425.6 (j) A program licensed as an adult day care center licensed under Minnesota Rules,
425.7 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on
425.8 the following schedule:

425.9	Licensed Capacity	License Fee
425.10	1 to 24 persons	$500
425.11	25 to 49 persons	$700
425.12	50 to 74 persons	$900
425.13	75 to 99 persons	$1,100
425.14	100 or more persons	$1,300

425.15 (k) A program licensed to provide treatment services to persons with sexual
425.16 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
425.17 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(l) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

(m)(1) Effective for fees paid after July 1, 2017, a program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee of 0.27 percent of revenues derived from the provision of services that would require licensure under this chapter and that are specified under section 245D.03, subdivision 1, during the calendar year immediately preceding the year in which the license fee is paid. If the calculated fee is less than $450, the fee shall be $450.

(2) The commissioner shall calculate the licensing fee for providers of home and community-based services and supports under this paragraph and invoice the license holder annually. Upon challenge of the invoiced fee amount by the license holder, the commissioner shall provide the license holder with a report identifying the medical assistance claims paid by the commissioner to the license holder that formed the basis for the licensing fee calculation.

Sec. 2. Minnesota Statutes 2014, section 245A.10, subdivision 8, is amended to read:

Subd. 8. **Deposit of license fees.** A human services licensing account is created in the ~~state government~~ special revenue fund. Fees collected under subdivisions 3 and 4 must be deposited in the human services licensing account and are ~~annually~~ appropriated to the commissioner for licensing activities authorized under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2017.

Sec. 3. Minnesota Statutes 2015 Supplement, 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~~ Service, Senior Companion Program ~~established~~ under ~~the Domestic Volunteer Service Act of 1973, Public Law 98-288~~ Code of Federal Regulations, title 45, subpart B, chapter 25, part 2551 et seq.;

(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

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

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

(1) intervention services, including:

(i) behavioral 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.

EFFECTIVE DATE. Paragraph (b), clause (2), of this section is effective the day following final enactment. Paragraph (b), clause (7), of this section is effective July 1, 2017.

Sec. 4. Minnesota Statutes 2014, section 256B.0949, is amended to read:

256B.0949 ~~AUTISM~~ EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION BENEFIT.

Subdivision 1. **Purpose.** This section creates ~~a new~~ the early intensive developmental and behavioral intervention (EIDBI) benefit to provide early intensive intervention to a child with an autism spectrum disorder diagnosis or related condition. This benefit must provide coverage for ~~diagnosis~~ a comprehensive, multidisciplinary assessment, ongoing progress evaluation, and medically necessary early intensive treatment of autism spectrum disorder or related conditions.

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

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide EIDBI and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. The definition of "agency" includes licensed individual professionals who practice independently and act as an agency.

~~(b)~~ (c) "Autism spectrum disorder ~~diagnosis~~" ~~is defined by diagnostic code 299~~ or "ASD" has the meaning given in ~~the current version of~~ the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(d) "ASD and related conditions" means a condition that is found to be closely related to autism spectrum disorder and may include but is not limited to autism, Asperger's syndrome, pervasive developmental disorder-not otherwise specified, fetal alcohol spectrum disorder, Rhett's syndrome, and autism-related diagnosis as identified under the current version of the DSM and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of persons with ASD;

(3) requires treatment or services similar to those required for persons with ASD; and

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits in one or more of the following related developmental domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning;

(vii) safety; and

(viii) level of support needed.

~~(c)~~ (e) "Child" means a person under the age of ~~18~~ 21.

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(f) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, progress monitoring, and treatment review for each client. Clinical supervision is provided by a qualified supervising professional who takes full professional responsibility for the services provided by each of the supervisees. All EIDBI services must be billed by and either provided by or under the clinical supervision of a qualified supervising professional.

~~(d)~~ (g) "Commissioner" means the commissioner of human services, unless otherwise specified.

(h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a child's developmental status to determine medical necessity for EIDBI based on the requirements in subdivision 5.

~~(e)~~ (i) "Early intensive developmental and behavioral intervention benefit" or "EIDBI" means ~~autism treatment options~~ intensive treatment interventions based in behavioral and developmental science~~, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models~~ that include the services covered under subdivision 13.

~~(f)~~ (j) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and children, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(k) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates child and family information from the comprehensive multidisciplinary evaluation for a child who meets medical necessity for the early intensive developmental and behavioral intervention benefit. An individual treatment plan must meet the standards in subdivision 6.

(l) "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. 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.

(m) "Level I treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (a).

(n) "Level II treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (b).

(o) "Level III treatment provider" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (c).

~~(g)~~ (p) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

(q) "Person-centered" means services that respond to the identified needs, interests, values, preferences, and desired outcomes of the child and the child's legal representative. Person-centered planning identifies what is important to the child and the child's legal representative, respects each child's history, dignity, and cultural background, and allows inclusion and participation in the child's community.

(r) "Qualified CMDE provider" means a person meeting the CMDE provider qualification requirements under subdivision 5a.

(s) "Qualified EIDBI professional" means a person who is a QSP or a level I, level II, or level III treatment provider.

(t) "Qualified supervising professional" or "QSP" means a person who meets the EIDBI provider qualifications under subdivision 15, paragraph (d).

Subd. 3. ~~**Initial**~~ **EIDBI eligibility.** This benefit is available to a child enrolled in medical assistance who:

(1) has ~~an autism spectrum disorder~~ a diagnosis of ASD or a related condition that meets the criteria of subdivision 4; and

(2) ~~has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services; and~~

~~(3)~~ meets the criteria for medically necessary autism early intensive intervention services.

Subd. 3a. **Culturally and linguistically appropriate requirement.** The child's and family's primary spoken language, culture, preferences, goals, and values must be reflected throughout the process of diagnosis, CMDE, ITP development, ITP progress evaluation monitoring, family or caregiver training and counseling services, and coordination of care. The qualified CMDE provider and QSP must determine how to adapt the evaluation, treatment recommendations, and ITP to the culture, language, and values of the child and family. A language interpreter must be provided consistent with section 256B.0625, subdivision 18a. Providers must have a limited English proficiency (LEP) plan in compliance with title VI of the Civil Rights Act of 1964, United States Code, title 42, section 2000d et seq. Communication and language assistance must comply with national standards for culturally and linguistically appropriate services (CLAS), as published by the United States Department of Health and Human Services.

Subd. 4. **Diagnosis.** (a) A diagnosis of ASD or a related condition must:

(1) be based upon current DSM criteria including direct observations of the child and ~~reports~~ information from ~~parents~~ the child's legal representative or primary caregivers; ~~and~~

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional; and

(3) meet the requirements of Minnesota Rules, part 9505.0372, subpart 1, items B and C.

(b) Additional ~~diagnostic~~ assessment information may be considered to complete a diagnostic assessment including ~~from~~ specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

Subd. 5. **~~Diagnostic assessment~~ Comprehensive multidisciplinary evaluation (CMDE).** (a) The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:

~~(1)~~ an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child, which must be administered by a licensed mental health professional, must include medical or assessment information from the child's physician or advanced practice registered nurse, and may also include observations from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation therapists, licensed school personnel, or mental health professionals~~; and~~

~~(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended~~.

A CMDE must be completed to determine the medical necessity of EIDBI services.

(b) The CMDE must include and document the child's legal representative's or caregiver's preferences for involvement in the child's treatment that is culturally and linguistically appropriate as required under subdivision 3a.

Subd. 5a. **CMDE provider qualification requirements.** A qualified CMDE provider must:

(1) be a licensed physician or advanced practice registered nurse or a mental health professional or a mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD or equivalent documented coursework at the graduate level by an accredited university in the following content areas: ASD diagnosis, ASD treatment strategies, and child development;

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license; and

(4) have knowledge and provide information about the range of current EIDBI treatment modalities recognized by the commissioner.

Subd. 6. **Individual treatment plan (ITP).** (a) The qualified EIDBI professional who integrates and coordinates child and family information from the CMDE and ITP progress evaluation monitoring process to develop the ITP must develop and monitor the ITP.

(b) The ITP must be individualized, person-centered, and culturally and linguistically appropriate, as required under subdivision 3a. The ITP must specify the medically necessary treatment and services, including baseline data, primary goals and target objectives, ITP progress evaluation results and goal mastery data, and any significant changes in the child's condition or family circumstances. Each child's ~~treatment plan~~ ITP must be~~:~~

~~(1)~~ based on the diagnostic assessment and CMDE summary information specified in subdivisions 4 and 5~~;~~

~~(2) coordinated with medically necessary occupational, physical, and speech and language therapies, special education, and other services the child and family are receiving;~~

~~(3) family-centered;~~

~~(4) culturally sensitive; and~~

~~(5) individualized based on the child's developmental status and the child's and family's identified needs~~.

~~(b)~~ (c) The ~~treatment plan~~ ITP must specify the primary treatment goals and target objectives, including baseline measures and projected dates of accomplishment. The ITP must include:

~~(1) child's goals which are developmentally appropriate, functional, and generalizable;~~

~~(2) treatment modality;~~

~~(3) treatment intensity;~~

~~(4) setting; and~~

~~(5) level and type of parental or caregiver involvement.~~

(1) the treatment method that shall be used to meet the goals and objectives, including:

(i) the frequency, intensity, location, and duration of each service provided;

(ii) the level of parent or caregiver training and counseling;

(iii) any changes or modifications to the physical and social environments necessary when the services are provided;

(iv) any specialized equipment and materials required;

(v) techniques that support and are consistent with the child's communication mode and learning style; and

(vi) the name of the QSP; and

(2) the discharge criteria that shall be used and a defined transition plan to assist the child and the child's legal representative to transition to other services. The transition plan shall include:

(i) protocols for changing service when medically necessary;

(ii) how the transition will occur;

(iii) the time allowed to make the transition. Up to 30 days of continued service is allowed while the transition plan is being developed. Services during this plan development period shall be consistent with the ITP. The plan development period begins when the child or the child's legal representative receives notice of termination of EIDBI and ends when EIDBI is terminated; and

(iv) a description of how the parent or guardian will be informed of and involved in the transition.

~~(c)~~ (d) Implementation of the ~~treatment~~ ITP must be supervised by a QSP ~~professional with expertise and training in autism and child development who is a licensed physician, advanced practice registered nurse, or mental health professional~~ .

~~(d)~~ (e) The ~~treatment plan~~ ITP must be submitted to the commissioner for approval in a manner determined by the commissioner for this purpose.

~~(e) Services authorized must be consistent with the child's approved treatment plan.~~

(f) Services included in the ~~treatment plan~~ ITP must meet all applicable requirements for medical necessity and coverage.

Subd. 6a. **Coordination with other benefits.** (a) Services provided under this section are not intended to replace services provided in school or other settings. Each child's CMDE must document that EIDBI services coordinate with, but do not include or replace, special education and related services defined in the child's individualized education plan (IEP), or individualized family service plan (IFSP), when the service is available under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), United States Code, title 20, chapter 33, through a local education agency. This provision does not preclude EIDBI treatment during school hours.

(b) The commissioner shall integrate medical authorization procedures for this benefit with authorization procedures for other health and mental health services and home and community-based services to ensure that the child receives services that are the most appropriate and effective in meeting the child's needs. Programs for birth to three years of age and additional resources shall also coordinate with EIDBI services. Resources for individuals over 18 years of age must also be coordinated with the services in this section.

Subd. 7. ~~**Ongoing eligibility**~~ **ITP progress evaluation monitoring.** (a) An ~~independent~~ ITP progress evaluation ~~conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development~~ must be completed after each six months of treatment, or more frequently as determined by the ~~commissioner~~ qualified CMDE provider, to determine if progress is being made toward ~~achieving~~ targeted functional and generalizable goals ~~and meeting functional goals contained~~ specified in the ~~treatment plan~~ ITP. Based on the results of ITP progress evaluation, the ITP must be adjusted as needed and must document that the child continues to meet medical necessity for EIDBI or is referred to other services.

(b) The ITP progress evaluation must include:

(1) ~~the treating provider's report;~~

~~(2) parental or caregiver~~ input from the child's caregiver or the child's legal representative;

~~(3)~~ (2) an ~~independent~~ observation of the child ~~which can be~~ that is performed by ~~the child's~~ a QSP or a level I or level II treatment provider and may include observation information from licensed special education staff or other licensed health care providers;

(3) documentation of current level of performance on primary treatment goal domains including when goals and objectives are achieved, changed, or discontinued;

(4) any significant changes in the child's condition or family circumstances;

~~(4)~~ (5) any treatment plan modifications and the rationale for any changes made including treatment modality, intensity, frequency, and duration; and

~~(5)~~ (6) recommendations for continued treatment ~~services~~.

(c) ITP progress ~~evaluations~~ evaluation must be submitted to the commissioner and the child or legal representative in a manner determined by the commissioner for ~~this purpose~~ the reauthorization of EIDBI services.

(d) A child who continues to ~~achieve generalizable goals and~~ make reasonable progress toward treatment goals as specified in the ~~treatment plan~~ ITP is eligible to continue receiving ~~this benefit~~ EIDBI services.

(e) A child's treatment shall continue during the ITP progress evaluation using the process determined under ~~subdivision 8, clause (8)~~ this subdivision. Treatment may continue during an appeal pursuant to section 256.045.

Subd. 8. **Refining the benefit with stakeholders.** The commissioner must ~~develop the implementation~~ refine the details of the benefit in consultation with stakeholders and consider recommendations from ~~the Health Services Advisory Council,~~ the Department of Human Services ~~Autism Spectrum Disorder~~ Early Intensive Developmental and Behavioral Intervention Benefit Advisory Council, ~~the Legislative Autism Spectrum Disorder Task Force,~~ the EIDBI learning collaborative, and the ASD Interagency Task Force of the Departments of Health, Education, Employment and Economic Development, and Human Services. ~~The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval.~~ The ~~implementation~~ details must include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other ~~types of~~ professionals certified in other treatment approaches recognized by the Department of Human Services or trained in autism spectrum disorder and child development should be added as ~~mental health or other~~ professionals ~~for~~ qualified to provide EIDBI treatment supervision or other functions under medical assistance;

(2) ~~development of initial,~~ refinement of uniform parameters for comprehensive multidisciplinary ~~diagnostic assessment information~~ evaluation and ~~progress evaluation~~ ongoing ITP progress evaluation monitoring standards;

(3) the design of an effective and consistent process for assessing ~~parent~~ the child's legal representative's and ~~caregiver capacity~~ caregiver's preferences and options to participate in the child's early intervention treatment and efficacy of methods ~~of involving the parents~~ to involve and educate the child's legal representative and caregivers in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform provider standards and qualifications; standards for a comprehensive~~,~~ multidisciplinary ~~diagnostic assessment~~ evaluation; medical necessity determination; efficacy of treatment apparatus, including modality, intensity, frequency, and duration; and ~~progress evaluation~~ progress-monitoring processes ~~and standards~~ to support quality improvement of ~~early intensive intervention~~ EIDBI services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, Employment and Economic Development, and Education;

(6) evaluation, on an ongoing basis, of ~~research regarding the~~ program EIDBI outcomes and efficacy of treatment ~~modalities~~ methods provided to children under this benefit; and

(7) as provided under subdivision 18, determination of the availability of ~~licensed physicians, nurse practitioners, and mental health professionals~~ qualified EIDBI professionals with necessary expertise and training in autism spectrum disorder and related conditions throughout the state to assess whether there are sufficient professionals ~~to require involvement of both a physician or nurse practitioner and a mental health professional~~ to provide timely access and prevent delay in the ~~diagnosis and~~ CMDE and treatment of ~~young children, so as to implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and~~ ASD and related conditions.

~~(8) development of the process for the progress evaluation that will be used to determine the ongoing eligibility, including necessary documentation, timelines, and responsibilities of all parties.~~

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence. EIDBI treatment methods approved by the Department of Human Services must:

(1) cause no harm to the individual child or family;

(2) be provided in an individualized manner to meet the varied needs of each child and family;

(3) be developmentally appropriate and highly structured, with well-defined goals and objectives that provide a strategic direction for treatment;

(4) be regularly evaluated and adjusted as needed;

(5) be based in recognized principles of developmental and behavioral science;

(6) utilize sound practices that are replicable across providers and maintain the fidelity of the specific approach;

(7) demonstrate an evidentiary basis;

(8) have goals and objectives that are measurable, achievable, and regularly evaluated to ensure that adequate progress is being made;

(9) be provided intensively with a high adult-to-child ratio; and

(10) include active child and legal representative participation in decision-making, knowledge- and capacity-building, and developing and implementing the child's ITP.

(b) Before ~~the changes~~ revisions in Department of Human Services recognized treatment modalities become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

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Subd. 10. **Coordination between agencies.** The commissioners of human services and education must develop the capacity to coordinate services and information including diagnostic, functional, developmental, medical, and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. **Federal approval of the autism benefit.** (a) This section shall apply to state plan services under title XIX of the Social Security Act when federal approval is granted under a 1915(i) waiver or other authority which allows children eligible for medical assistance through the TEFRA option under section 256B.055, subdivision 12, to qualify and includes children eligible for medical assistance in families over 150 percent of the federal poverty guidelines.

(b) The commissioner may use the federal authority for a Medicaid state plan amendment under Early and Periodic Screening Diagnosis and Treatment (EPSDT), United States Code, title 42, section 1396D(R)(5), or other Medicaid provision for any aspect or type of treatment covered in this section if new federal guidance is helpful in achieving one or more of the purposes of this section in a cost-effective manner. Notwithstanding subdivisions 2 and 3, any treatment services submitted for federal approval under EPSDT shall include appropriate medical criteria to qualify for the service and shall cover children through age 20.

Subd. 12. **Autism benefit; training provided.** After approval of the autism early intensive intervention benefit under this section by the Centers for Medicare and Medicaid Services, the commissioner shall provide statewide training on the benefit for culturally and linguistically diverse communities. Training for autism service providers on culturally appropriate practices must be online, accessible, and available in multiple languages. The training for families, lead agencies, advocates, and other interested parties must provide information about the benefit and how to access it.

Subd. 13. **Covered services.** (a) The services described in paragraphs (b) to (i) are eligible for reimbursement by medical assistance under this section.

(b) EIDBI interventions are a variety of individualized, intensive treatment methods approved by the department that are based in behavioral and developmental science consistent with best practices on effectiveness. Services must address the participant's medically necessary treatment goals and be provided by a qualified supervising professional or a level I, level II, or level III treatment provider. Services are targeted to develop, enhance, or maintain the individual developmental skills of a child with ASD and related conditions to improve functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care, safety, and level of support needed. EIDBI interventions include, but are not limited to:

(1) applied behavioral analysis (ABA);

(2) developmental individual-difference relationship-based model (DIR/Floortime);

(3) early start Denver model (ESDM);

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(4) PLAY project; or

(5) relationship development intervention (RDI).

A provider may use one or more of the treatment interventions in clauses (1) to (5) as the primary modality for treatment as a covered service, or several treatment interventions in combination as the primary modality of treatment, as approved by the commissioner. Additional treatment interventions may be used upon approval by the commissioner. A provider that identifies and provides assurance of qualifications for a single specific treatment modality must document the required qualifications to meet fidelity to the specific model.

(c) EIDBI intervention observation and direction is the clinical direction and oversight by a QSP or a level I or level II treatment provider regarding provision of EIDBI services to a child, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a child. EIDBI intervention observation and direction informs any modifications of the methods to support the accomplishment of outcomes in the ITP. Observation and direction provides a real-time response to EIDBI interventions to maximize the benefit to the child.

(d) CMDE is a comprehensive evaluation of the child's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider.

(e) ITP development and monitoring is development of the initial, annual, and progress monitoring of ITPs. This service documents, provides oversight and on-going evaluation of child treatment and progress on targeted goals and objectives, and integrates and coordinates child and family information from the CMDE and progress monitoring evaluations. The ITP must meet the requirements of subdivision 6. ITP progress evaluation monitoring must meet the requirements of subdivision 7. This service must be reviewed and completed by a QSP, and may include input from a level I or level II treatment provider.

(f) Family caregiver training and counseling is specialized training and education a family or primary caregiver receives to understand the child's developmental status and help with the child's needs and development. This service must be provided by a QSP or a level I or level II treatment provider.

(g) A coordinated care conference is a voluntary face-to-face meeting with the child and family to review the CMDE or progress monitoring results and to coordinate and integrate services across providers and service-delivery systems to develop the ITP. This service must be provided by a QSP and may include the CMDE provider or the level I or level II treatment provider.

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(h) Travel time is allowable billing for traveling to and from the recipient's home, school, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide face-to-face EIDBI intervention, observation and direction, or family caregiver training and counseling. EIDBI recipients must have an ITP specifying the reasons the provider must travel to the recipient's home, a community setting, or place of service outside of an EIDBI center, clinic, or office.

(i) Medical assistance covers medically necessary EIDBI services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week.

Subd. 14. **Service recipient rights.** A child or the child's legal representative has the right to:

(1) protection as defined under the health care bill of rights under section 144.651;

(2) designate an advocate of the child's or the child's legal representative's choice to be present in all aspects of the child's and family's services at the request of the child or the child's legal representative;

(3) be informed of the agency policy on assigning staff to a child;

(4) receive the opportunity to observe the child while receiving services;

(5) receive services in a manner that respects and takes into consideration the child's and the legal representative's culture, values, religion, and preferences in accordance with subdivision 3a;

(6) be free from mechanical restraint or seclusion using locked doors except in emergencies as defined in section 245D.02, subdivision 8a;

(7) be under the supervision of a responsible adult at all times;

(8) receive notification from the agency within 24 hours if the child is injured while receiving services, including what occurred and how agency staff responded to the injury;

(9) request a voluntary coordinated care conference; and

(10) request an independent CMDE provider of the child's or legal representative's choice.

Subd. 15. **EIDBI provider qualifications.** (a) A level I treatment provider must be employed by an EIDBI agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or allied fields, including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health or child development field from an accredited college or university and advanced certification in a treatment method recognized by the Department of Human Services; or

(iii) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience including meeting all registration, supervision, and continuing education requirements of the certification.

(b) A level II treatment provider must be employed by an EIDBI provider agency and be either:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy; and

(i) has at least 1,000 hours of clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board; or

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board or is certified in one of the other treatment modalities recognized by the Department of Human Services;

(2) a person who:

(i) has an associate's degree in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

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(ii) has at least 2,000 hours of supervised clinical experience in delivering treatment to children with ASD. Hours worked as a behavioral aide or level III treatment provider may be included in the required hours of experience;

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to children with ASD. Hours worked as a mental health behavioral aide or developmental or level III treatment provider may be included in the required hours of experience;

(4) a person who is a graduate student in a behavioral science, child development science, or allied field and is receiving clinical supervision by a qualified supervising professional affiliated with an agency to meet the clinical training requirements for experience and training with children with ASD; or

(5) a person who is at least 18 years old and who:

(i) is fluent in the non-English language spoken in the child's home or works with a tribal entity that represents the child's culture;

(ii) meets level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or qualified level I treatment provider at least once a week until 1,000 hours of supervised clinical experience are met.

(c) A level III treatment provider must be employed by an EIDBI provider agency, have completed the level III training requirement, be at least 18 years old, and have at least one of the following:

(1) a high school diploma or general equivalency diploma (GED);

(2) fluency in the non-English language spoken in the child's home or works with a tribal entity that represents the child's culture; or

(3) one year of experience as a primary PCA, community health worker, waiver service provider, or special education assistant to a child with ASD within the previous five years.

(d) A qualified supervising professional must be employed by an EIDBI agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in the examining or treating of children with ASD or related conditions or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

Subd. 16. **Agency responsibilities.** (a) The agency must:

(1) exercise and protect the service recipient's rights;

(2) offer services that are person-centered and culturally and linguistically appropriate as required under subdivision 3a;

(3) allow people to make informed decisions concerning CMDE, treatment recommendations, alternatives considered, and possible risks of services;

(4) have a written policy that identifies steps to resolve issues collaboratively when possible;

(5) except for emergency situations, provide adequate notice of transition, subject to staff availability, of transition from EIDBI services prior to implementing a transition plan with the family;

(6) provide notice as soon as possible when issues arise about provision of EIDBI services;

(7) provide the legal representative with prompt notification if the child is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the child. Copies of all incident and injury reports must remain on file at the agency for at least one year. An incident is when any of the following occur:

(i) an illness, accident, or injury which requires first aid treatment;

(ii) a bump or blow to the head; or

(iii) an unusual or unexpected event that jeopardizes the safety of children or staff, including a child leaving the agency unattended; and

(8) prior to starting services, provide the child or the child's legal representative a plain-spoken description of the treatment method or methods that the child shall receive, including the staffing certification levels and training of the staff who shall provide the treatment or treatments.

(b) When delivering the ITP, and annually thereafter, agencies must provide the child or the child's legal representative with:

(1) a written copy of the child's rights and agency responsibilities;

(2) a verbal explanation of rights and responsibilities;

(3) reasonable accommodations to provide the information in other formats or languages as needed to facilitate understanding of the rights and responsibilities; and

(4) documentation in the child's file of the date that the child or the child's legal representative received a copy and explanation of the client's rights and agency responsibilities.

Subd. 17. **EIDBI agency qualifications, general requirements, and duties.** (a) EIDBI agencies delivering services under this section shall:

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws for EIDBI;

(3) verify and maintain records of all services provided to the child or the child's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(4) not have had a lead agency contract or provider agreement discontinued due to a conviction of fraud, or not have had an owner, board member, or manager fail a state or FBI-based criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General while enrolled or seeking enrollment as a Minnesota health care program provider;

(5) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services;

(6) have an office located in Minnesota; and

(7) conduct a criminal background check on an individual who has direct contact with the child or the child's legal representative.

(b) an EIDBI agency shall:

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

(2) provide the child or the child's legal representative with a copy of the service-related rights under subdivision 14 at the start of services;

(3) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27; and

(4) provide training for all agency staff on the Maltreatment of Minors Act and the Vulnerable Adult Protection Act requirements and responsibilities, including mandated and voluntary reporting, nonretaliation, and the agency's policy for all staff on how to report suspected abuse and neglect.

Senate Language UEH2749-1

House Language H3467-3

Subd. 18. **Provider shortage; authority for exceptions.** (a) In consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council, including agencies, professionals, parents of children with ASD, and advocacy organizations, the commissioner shall determine if a shortage of qualified EIDBI providers exists. For the purposes of this subdivision, "shortage of qualified EIDBI providers" means a lack of availability of providers who meet the EIDBI provider qualification requirements under subdivision 15 that results in the delay of access to timely services under this section, or that significantly impairs the ability of a provider agency to have sufficient qualified providers to meet the requirements of this section. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide. The commissioner shall also consider the availability of various types of treatment methods covered under this section.

(b) If the commissioner determines that a shortage of qualified providers exists under paragraph (a), the commissioner, in consultation with the EIDBI Advisory Council and stakeholders, must establish processes and criteria for granting an exception. The commissioner may grant an exception to any of the following requirements, but only if an exception would not compromise child safety nor diminish the quality and effectiveness of the treatment provided:

(1) EIDBI provider qualifications under this section;

(2) medical assistance provider enrollment requirements under Minnesota Rules, part 9505.0195; or

(3) applicable provider or agency standards or requirements.

(c) If the commissioner, in consultation with the EIDBI Advisory Council and stakeholders, determines that a shortage no longer exists, the commissioner must submit a notice that a shortage no longer exists to the chairs and ranking minority members of the senate and the house of representatives committees with jurisdiction over health and human services. The commissioner must post the notice for public comment for 30 days. The commissioner shall consider all public comments before the commissioner makes a final determination regarding the termination and timeline for termination of the commissioner's authority to grant exceptions under this subdivision. Until the shortage ends, the commissioner shall provide an update annually to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over health and human services on the status of the provider shortage and exception process.

EFFECTIVE DATE. Subdivisions 1, 5a, 13, and 18 are effective the day following final enactment. Subdivisions 2 to 3a, 5, 6 to 9, and 14 to 17 are effective August 1, 2016. Subdivision 4 is effective January 1, 2017.

Senate Language UEH2749-1

House Language H3467-3

Sec. 15. Minnesota Statutes 2015 Supplement, section 256B.431, subdivision 36, is amended to read:

Subd. 36. **Employee scholarship costs and training in English as a second language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate. For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for newly hired and recently graduated registered nurses and licensed practical nurses, and training expenses for nursing assistants as ~~defined~~ specified in section 144A.611, ~~subdivision~~ subdivisions 2 and 4, who are newly hired and have graduated within the last 12 months; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) All facilities may annually request a rate adjustment under this subdivision by submitting information to the commissioner on a schedule and in a form supplied by the commissioner. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this subdivision is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this subdivision.

(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

Senate Language UEH2749-1

House Language H3467-3

Sec. 16. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 13, is amended to read:

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single bed room incentives under section 256B.431, subdivision 42; property taxes, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under subdivision 46c; performance-based incentive payments under subdivision 46d; special dietary needs under subdivision 51b; and PERA.

Sec. 5. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 30, is amended to read:

Subd. 30. **Median total care-related cost per diem and other operating per diem determined.** (a) The commissioner shall determine the median total care-related per diem to be used in subdivision 50 and the median other operating per diem to be used in subdivision 51 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median ~~direct care cost~~ total care-related per diem for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2016.

Sec. 17. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

Senate Language UEH2749-1

House Language H3467-3

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(d) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(e) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.

(f) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

~~(f)~~ (g) The single bed room incentives shall be as determined under section 256B.431, subdivision 42.

~~(g)~~ (h) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

~~(h)~~ (i) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

~~(i)~~ (j) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

~~(j)~~ (k) The portion related to quality improvement incentive payment rate adjustments shall be as determined under subdivision 46c.

~~(k)~~ (l) The portion related to performance-based incentive payments shall be as determined under subdivision 46d.

~~(l)~~ (m) The portion related to special dietary needs shall be the per diem amount determined under subdivision 51b.

~~(m)~~ (n) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to ~~(l)~~ (m).

Sec. 6. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 66, is amended to read:

Sec. 18. Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 66, is amended to read:

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Subd. 66. **Nursing facilities in border cities.** (a) Rate increases under this section for a facility located in Breckenridge are effective for the rate year beginning January 1, 2016, and annually thereafter~~.~~. Rate increases under this section for a facility located in Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

(b) Operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge or Moorhead, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The commissioner must make the comparison required under this subdivision on October 1 of each year. The adjustment under this subdivision applies to the rates effective on the following January 1.

(c) The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. ~~If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall not be subject to those limits for that rate year.~~ If a facility's rate is increased under this subdivision, the facility is not subject to the total care-related limit in subdivision 50 and is not limited to the other operating price established in subdivision 51. This subdivision shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section, section 256B.431, or section 256B.434.

Sec. 7. Minnesota Statutes 2014, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Annual data submission.** (a) In a manner determined by the commissioner, home and community-based services waiver providers enrolled under this section shall submit data to the commissioner on the following:

(1) wages of workers;

(2) benefits paid;

(3) staff retention rates;

(4) amount of overtime paid;

(5) amount of travel time paid;

(6) vacancy rates; and

(7) other data elements determined by the commissioner.

(b) The commissioner may adjust reporting requirements for an individual self-employed worker.

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Subd. 66. **Nursing facilities in border cities.** (a) Rate increases under this section for a facility located in Breckenridge are effective for the rate year beginning January 1, 2016, and annually thereafter~~.~~. Rate increases under this section for a facility located in Moorhead are effective for the rate year beginning January 1, 2020, and annually thereafter.

(b) Operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the ~~city~~ cities of Breckenridge or Moorhead, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The commissioner must make the comparison required under this subdivision on October 1 of each year. The adjustment under this subdivision applies to the rates effective on the following January 1.

(c) The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. ~~If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall not be subject to those limits for that rate year.~~ If a facility's rate is increased under this subdivision, the facility is not subject to the total care-related limit in subdivision 50 and is not limited to the other operating price established in subdivision 51. This subdivision shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section, section 256B.431, or section 256B.434.

(c) This subdivision also applies to a provider of personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; consumer support grants under section 256.476; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; intermediate care facilities for persons with developmental disabilities under section 256B.501; and day training and habilitation providers serving residents of intermediate care facilities for persons with developmental disabilities under section 256B.501.

(d) This data shall be submitted annually each calendar year on a date specified by the commissioner. The commissioner shall give a provider at least 30 calendar days to submit the data. Failure to submit the data requested may result in delays to medical assistance reimbursement.

(e) Individually identifiable data submitted to the commissioner in this section are considered private data on an individual, as defined by section 13.02, subdivision 12.

(f) The commissioner shall analyze data annually for workforce assessments and its impact on service access.

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

Sec. 8. Minnesota Statutes 2015 Supplement, 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~~ each 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);

(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.

Sec. 9. Minnesota Statutes 2014, 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 (SOC code 31-1012); 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 (SOC code 31-1012); 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 (SOC code 31-1012); 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, except in a family foster care setting, the wage is $2.80 per hour;

(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);

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(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 (SOC code 31-1012); 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 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 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 supported employment staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 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);

(12) 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 (SOC code 31-1012);

(13) 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 (SOC code 31-1012); 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) 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 (SOC code 31-1012);

(15) 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 (SOC code 31-1012);

(16) 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;

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

(18) for licensed practical nurse, the basic wage is $18.64 per hour.

(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:

(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 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;

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

(4) program plan supports ratio: 3.1 percent;

(5) client programming and supports ratio: 8.6 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;

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

(4) program plan support ratio: 3.1 percent;

(5) client programming and support ratio: 8.6 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.

(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 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.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraphs (b) to (g); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (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. No later than January 15, 2017, the commissioner shall make recommendations for the incorporation of the cost of licensing fees as specified under section 245A.10, subdivision 4, paragraph (m), into the rate framework.

Sec. 10. Minnesota Statutes 2015 Supplement, 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) 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~~ lead agency during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014.

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

(4) values for indirect services;

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

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

(13) 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) any changes in state or federal law with an impact on the underlying cost of providing home and community-based services.

(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, 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) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(h) 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~~ lead agency 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) 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.

Sec. 11. Minnesota Statutes 2014, section 256B.4914, subdivision 11, is amended to read:

Subd. 11. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in ~~county~~ lead agency contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

Sec. 12. Minnesota Statutes 2015 Supplement, section 256B.4914, subdivision 14, is amended to read:

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

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

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

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

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

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

(4) an individual's service needs cannot be met through a weighted county average rate as defined in section 256B.4913, subdivision 4a.

(d) Exception requests must include the following information:

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

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

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) any contingencies for approval.

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

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

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

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2015 Supplement, section 256B.4914, subdivision 15, is amended to read:

Subd. 15. **~~County or tribal~~ Lead agency allocations.** (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning January 1, 2014, the commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on ~~county~~ lead agency allocations upon implementation of the disability waiver rates system.

(c) Lead agencies exceeding their allocations shall be subject to the provisions under sections 256B.0916, subdivision 11, and 256B.49, subdivision 26.

Sec. 14. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2016.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by 2.72 percent for the rate period beginning July 1, 2016, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through with these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) the following services within the home and community-based waiver for persons with developmental disabilities under Minnesota Statutes, section 256B.092: extended personal care, personal support, chore, respite care services except for crisis respite services, homemaker cleaning services, and consumer-directed community supports budgets;

(2) the following services within the community access for disability inclusion waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(3) the following services within the community alternative care waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

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(4) the following services within the brain injury waiver under Minnesota Statutes, section 256B.49: extended personal care, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(5) the following services within the elderly waiver under Minnesota Statutes, section 256B.0915: extended personal care, companion, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(6) the following services within the alternative care program under Minnesota Statutes, section 256B.0913: personal care, companion, chore, respite care services, homemaker cleaning services, and consumer-directed community supports budgets;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivision 6a or 19a; and

(8) consumer support grants under Minnesota Statutes, section 256.476.

(c) A managed care plan or county-based purchasing plan receiving state payments for the services in paragraph (b) must include the increases in paragraph (a) in payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a 2.72 percent increase for the specified services provided on or after July 1, 2016.

(d) Counties and tribes shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

(e) To implement the provisions of this section, the commissioner shall increase applicable service rates in the disability waiver payment system authorized in Minnesota Statutes, sections 256B.4913 and 256B.4914.

(f) A provider that receives a rate adjustment under paragraph (a) shall use 90 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after July 1, 2016, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider; and

(2) persons paid by the provider under a management contract.

(g) Compensation-related costs include:

(1) wages and salaries, including overtime and travel time;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other employee benefits provided, such as training of employees, as specified in the distribution plan and required under paragraph (i) and approved by the commissioner.

(h) Nothing in this subdivision prevents a provider as an employer from allocating the increase in revenues across the eligible compensation-related costs listed in paragraph (g).

(i) For a provider that has employees who are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (j) for the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to have met all the requirements of this section for the members of the bargaining unit. Upon request, the provider shall produce a letter of acceptance for the commissioner.

(j) A provider that receives a rate adjustment under paragraph (a) that is subject to paragraph (f) shall prepare and, upon request, submit to the commissioner a distribution plan that specifies the amount of money that is subject to the requirements of paragraph (f) the provider expects to receive, including the amount of money that will be distributed to increase compensation for employees. The distribution plan must also include the provider's policy for scheduling overtime. The provider's policy must not limit the scheduling of overtime hours where an individual's service needs are unmet without a worker exceeding 40 hours per week of work, consistent with the monthly work-hour limit under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (a), clause (10), and the service recipient's authorized hours. The provider's overtime scheduling policy must provide for a process that reliably and expeditiously provides services to recipients.

(k) Within six months of the effective date of the rate adjustment, the provider shall post the distribution plan required under paragraph (j) for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access and shall provide instructions for employees who do not believe they received the wage and other compensation-related increases specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that the employees may use to contact the commissioner or the commissioner's representative.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 15. **INSTRUCTION TO THE COMMISSIONER.**

The commissioner shall amend the medical assistance state plan for the EIDBI benefit, authorized under Minnesota Statutes, section 256B.0949, to reference relevant statutory sections. When duplicative of statutory language, the commissioner shall remove the language from the state plan.

Sec. 19. **EMPLOYMENT SERVICES PILOT PROJECT; DAKOTA COUNTY.**

(a) Within available appropriations, the commissioner of human services shall request, by October 1, 2016, necessary federal authority from the Centers for Medicare and Medicaid Services to implement a community-based employment services pilot project in Dakota County. The pilot project must be available to people who are receiving services through home and community-based waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, using a rate methodology consistent with the principles under Minnesota Statutes, section 256B.4914.

(b) Dakota County shall be:

(1) responsible for any portion of the state match of waiver expenses above the established disability waiver rates under Minnesota Statutes, section 256B.4914; and

(2) allocated resources for supportive employment services incurred by the use of employment exploration services, employment development services, and employment support services in Dakota County for Dakota County residents.

(c) The pilot project must provide the following employment services to people receiving services through the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49:

(1) "employment exploration services" defined as community-based orientation services that introduce a person to competitive employment opportunities in their community through individualized educational activities, learning opportunities, work experiences, and support services that result in the person making an informed decision about working in competitively paying jobs in community businesses;

(2) "employment development services" defined as individualized services that actively support a person to achieve paid employment in his or her community by assisting the person with finding paid employment, becoming self-employed, or establishing microenterprise businesses in the community; and

(3) "employment support services" defined as individualized services and supports that assist people with maintaining competitive, integrated employment by providing a broad range of training, coaching, and support strategies that not only assist individuals and work groups employed in paid job positions, but also support people working in self-employment opportunities and microenterprise businesses with all aspects of effective business operations. Employment support services must be provided in integrated community settings.

(d) The commissioner of human services shall consult with Dakota County on this pilot project and report the results of the project to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by January 15, 2019.

Senate Language UEH2749-1

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

460.10 The revisor of statutes shall codify Laws 2015, chapter 71, article 7, section 55, as
460.11 Minnesota Statutes, section 256B.0921.

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19.24 **EFFECTIVE DATE.** This section is effective July 1, 2016, or upon federal
19.25 approval, whichever is later, and expires on January 15, 2019. The commissioner of
19.26 human services shall notify the revisor of statutes when federal approval is obtained.

19.27 Sec. 20. **REVISOR'S INSTRUCTION.**

19.28 The revisor of statutes, in consultation with the Department of Human Services,
19.29 shall change the cross-references in Minnesota Rules, chapters 2960, 9503, and 9525,
19.30 resulting from the repealer adopted in rules found at 40 State Register 179. The revisor
19.31 may make technical and other necessary changes to sentence structure to preserve the
19.32 meaning of the text.

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