241.18 **ARTICLE 5** | 158.1 **ARTICLE 5**

241.19 **DISABILITY SERVICES** | 158.2 **DISABILITY SERVICES**

241.20 Section 1. Minnesota Statutes 2018, section 237.50, subdivision 4a, is amended to read:

241.21 Subd. 4a. **Deaf.** "Deaf" means a hearing loss of such severity that the ~~individual~~ person
241.22 must depend primarily upon visual communication such as writing, lip reading, sign language,
241.23 and gestures.

241.24 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
241.25 by October 1, 2019.

241.26 Sec. 2. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
241.27 read:

241.28 Subd. 4c. **Discounted telecommunications or Internet services.** "Discounted
241.29 telecommunications or Internet services" means private, nonprofit, and public programs
242.1 intended to subsidize or reduce the monthly costs of telecommunications or Internet services
242.2 for a person who meets a program's eligibility requirements.

242.3 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
242.4 by October 1, 2019.

242.5 Sec. 3. Minnesota Statutes 2018, section 237.50, subdivision 6a, is amended to read:

242.6 Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing loss resulting in a
242.7 functional limitation, but not to the extent that the ~~individual~~ person must depend primarily
242.8 upon visual communication in all interactions.

242.9 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
242.10 by October 1, 2019.

242.11 Sec. 4. Minnesota Statutes 2018, section 237.50, is amended by adding a subdivision to
242.12 read:

242.13 Subd. 6b. **Interconnectivity product.** "Interconnectivity product" means a device,
242.14 accessory, or application for which the primary function is use with a telecommunications
242.15 device. Interconnectivity product may include a cell phone amplifier, hearing aid streamer,
242.16 Bluetooth-enabled device that connects to a wireless telecommunications device, advanced
242.17 communications application for a smartphone, or other applicable technology.

242.18 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
242.19 by October 1, 2019.

242.20 Sec. 5. Minnesota Statutes 2018, section 237.50, subdivision 10a, is amended to read:

242.21 Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device
242.22 that (1) allows a person with a communication disability to have access to
242.23 telecommunications services as defined in subdivision 13, and (2) is specifically selected

242.24 by the Department of Human Services for its capacity to allow persons with communication
242.25 disabilities to use telecommunications services in a manner that is functionally equivalent
242.26 to the ability of ~~an individual~~ a person who does not have a communication disability. A
242.27 telecommunications device may include a ring signaler, an amplified telephone, a hands-free
242.28 telephone, a text telephone, a captioned telephone, a wireless device, a device that produces
242.29 Braille output for use with a telephone, and any other device the Department of Human
242.30 Services deems appropriate.

243.1 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
243.2 by October 1, 2019.

243.3 Sec. 6. Minnesota Statutes 2018, section 237.50, subdivision 11, is amended to read:

243.4 Subd. 11. **Telecommunications Relay Services.** "Telecommunications Relay Services"
243.5 or "TRS" means the telecommunications transmission services required under Federal
243.6 Communications Commission regulations at Code of Federal Regulations, title 47, sections
243.7 64.604 to 64.606. TRS allows ~~an individual~~ a person who has a communication disability
243.8 to use telecommunications services in a manner that is functionally equivalent to the ability
243.9 of ~~an individual~~ a person who does not have a communication disability.

243.10 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
243.11 by October 1, 2019.

243.12 Sec. 7. Minnesota Statutes 2018, section 237.51, subdivision 1, is amended to read:

243.13 Subdivision 1. **Creation.** (a) The commissioner of commerce shall:

243.14 (1) administer through interagency agreement with the commissioner of human services
243.15 a program to distribute telecommunications devices and interconnectivity products to eligible
243.16 persons who have communication disabilities; and

243.17 (2) contract with one or more qualified vendors that serve persons who have
243.18 communication disabilities to provide telecommunications relay services.

243.19 (b) For purposes of sections 237.51 to 237.56, the Department of Commerce and any
243.20 organization with which it contracts pursuant to this section or section 237.54, subdivision
243.21 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

243.22 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
243.23 by October 1, 2019.

243.24 Sec. 8. Minnesota Statutes 2018, section 237.51, subdivision 5a, is amended to read:

243.25 Subd. 5a. **Commissioner of human services duties.** (a) In addition to any duties specified
243.26 elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

243.27 (1) define economic hardship, special needs, and household criteria so as to determine
243.28 the priority of eligible applicants for initial distribution of devices and products and to

243.29 determine circumstances necessitating provision of more than one telecommunications
243.30 device per household;

244.1 (2) establish a method to verify eligibility requirements;

244.2 (3) establish specifications for telecommunications devices and interconnectivity products
244.3 to be provided under section 237.53, subdivision 3;

244.4 (4) inform the public and specifically persons who have communication disabilities of
244.5 the program; ~~and~~

244.6 (5) provide devices and products based on the assessed need of eligible applicants~~.~~; and

244.7 (6) assist a person with completing an application for discounted telecommunications
244.8 or Internet services.

244.9 (b) The commissioner may establish an advisory board to advise the department in
244.10 carrying out the duties specified in this section and to advise the commissioner of commerce
244.11 in carrying out duties under section 237.54. If so established, the advisory board must
244.12 include, at a minimum, the following persons:

244.13 (1) at least one member who is deaf;

244.14 (2) at least one member who has a speech disability;

244.15 (3) at least one member who has a physical disability that makes it difficult or impossible
244.16 for the person to access telecommunications services; and

244.17 (4) at least one member who is hard-of-hearing.

244.18 (c) The membership terms, compensation, and removal of members and the filling of
244.19 membership vacancies are governed by section 15.059. Advisory board meetings shall be
244.20 held at the discretion of the commissioner.

244.21 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
244.22 by October 1, 2019.

244.23 Sec. 9. Minnesota Statutes 2018, section 237.52, subdivision 5, is amended to read:

244.24 Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

244.25 (1) expenses of the Department of Commerce, including personnel cost, public relations,
244.26 advisory board members' expenses, preparation of reports, and other reasonable expenses
244.27 not to exceed ten percent of total program expenditures;

244.28 (2) reimbursing the commissioner of human services for purchases made or services
244.29 provided pursuant to section 237.53; and

244.30 (3) contracting for the provision of TRS required by section 237.54.

245.1 (b) All costs directly associated with the establishment of the program, the purchase and
245.2 distribution of telecommunications devices, and interconnectivity products, and the provision
245.3 of TRS are either reimbursable or directly payable from the fund after authorization by the
245.4 commissioner of commerce. The commissioner of commerce shall contract with one or
245.5 more TRS providers to indemnify the telecommunications service providers for any fines
245.6 imposed by the Federal Communications Commission related to the failure of the relay
245.7 service to comply with federal service standards. Notwithstanding section 16A.41, the
245.8 commissioner may advance money to the TRS providers if the providers establish to the
245.9 commissioner's satisfaction that the advance payment is necessary for the provision of the
245.10 service. The advance payment may be used only for working capital reserve for the operation
245.11 of the service. The advance payment must be offset or repaid by the end of the contract
245.12 fiscal year together with interest accrued from the date of payment.

245.13 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
245.14 by October 1, 2019.

245.15 Sec. 10. Minnesota Statutes 2018, section 237.53, is amended to read:
245.16 237.53 TELECOMMUNICATIONS ~~DEVICE~~ DEVICES AND
245.17 INTERCONNECTIVITY PRODUCTS.

245.18 Subdivision 1. **Application.** A person applying for a telecommunications device or
245.19 interconnectivity product under this section must apply to the program administrator on a
245.20 form prescribed by the Department of Human Services.

245.21 Subd. 2. **Eligibility.** To be eligible to obtain a telecommunications device or
245.22 interconnectivity product under this section, a person must:

245.23 (1) be able to benefit from and use the equipment for its intended purpose;

245.24 (2) have a communication disability;

245.25 (3) be a resident of the state;

245.26 (4) be a resident in a household that has a median income at or below the applicable
245.27 median household income in the state, except a person who is deafblind applying for a
245.28 Braille device may reside in a household that has a median income no more than 150 percent
245.29 of the applicable median household income in the state; and

245.30 (5) be a resident in a household that has telecommunications service or that has made
245.31 application for service and has been assigned a telephone number; or a resident in a residential
246.1 care facility, such as a nursing home or group home where telecommunications service is
246.2 not included as part of overall service provision.

246.3 Subd. 2a. **Assessment of needs.** After a person is determined to be eligible for the
246.4 program, the commissioner of human services shall assess the person's telecommunications
246.5 needs to determine: (1) the type of telecommunications device that provides the person with

246.6 functionally equivalent access to telecommunications services; and (2) appropriate
246.7 interconnectivity products for the person.

246.8 Subd. 3. **Distribution.** The commissioner of human services shall (1) purchase ~~and~~
246.9 ~~distribute~~ a sufficient number of telecommunications devices and interconnectivity products
246.10 so that each eligible household receives appropriate devices and products as determined
246.11 under section 237.51, subdivision 5a~~. The commissioner of human services shall~~, and (2)
246.12 distribute the devices and products to eligible households free of charge.

246.13 Subd. 4. **Training; information; maintenance.** The commissioner of human services
246.14 shall maintain the telecommunications devices and interconnectivity products until the
246.15 warranty period expires, and provide training, without charge, to first-time users of the
246.16 devices~~.~~ and products. The commissioner shall provide information about assistive
246.17 communications devices and products that may benefit a program participant and about
246.18 where a person may obtain or purchase assistive communications devices and products.
246.19 Assistive communications devices and products include a pocket talker for a person who
246.20 is hard-of-hearing, a communication board for a person with a speech disability, a one-to-one
246.21 video communication application for a person who is deaf, and other devices and products
246.22 designed to facilitate effective communication for a person with a communication disability.

246.23 Subd. 6. **Ownership.** Telecommunications devices and interconnectivity products
246.24 purchased pursuant to subdivision 3, clause (1), are the property of the state of Minnesota.
246.25 Policies and procedures for the return of distributed devices ~~from individuals who withdraw~~
246.26 ~~from the program or whose eligibility status changes~~ and products shall be determined by
246.27 the commissioner of human services.

246.28 Subd. 7. **Standards.** The telecommunications devices distributed under this section must
246.29 comply with the electronic industries alliance standards and be approved by the Federal
246.30 Communications Commission. The commissioner of human services must provide each
246.31 eligible person a choice of several models of devices, the retail value of which may not
246.32 exceed $600 for a text telephone, and a retail value of $7,000 for a Braille device, or an
246.33 amount authorized by the Department of Human Services for all other telecommunications
247.1 devices ~~and~~, auxiliary equipment, and interconnectivity products it deems cost-effective
247.2 and appropriate to distribute according to sections 237.51 to 237.56.

247.3 Subd. 9. **Discounted telecommunications or Internet services assistance.** The
247.4 commissioner of human services shall assist a person who is applying for telecommunication
247.5 devices and products in applying for discounted telecommunications or Internet services.

247.6 **EFFECTIVE DATE.** This section is effective July 1, 2019, and must be implemented
247.7 by October 1, 2019.

158.3 Section 1. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

158.4 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
158.5 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
158.6 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
158.7 for a physical location that will not be the primary residence of the license holder for the
158.8 entire period of licensure. If a license is issued during this moratorium, and the license
158.9 holder changes the license holder's primary residence away from the physical location of
158.10 the foster care license, the commissioner shall revoke the license according to section
158.11 245A.07. The commissioner shall not issue an initial license for a community residential
158.12 setting licensed under chapter 245D. When approving an exception under this paragraph,
158.13 the commissioner shall consider the resource need determination process in paragraph (h),
158.14 the availability of foster care licensed beds in the geographic area in which the licensee
158.15 seeks to operate, the results of a person's choices during their annual assessment and service
158.16 plan review, and the recommendation of the local county board. The determination by the
158.17 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

158.23 (3) new foster care licenses or community residential setting licenses determined to be
158.24 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
158.25 or regional treatment center; restructuring of state-operated services that limits the capacity
158.26 of state-operated facilities; or allowing movement to the community for people who no
158.27 longer require the level of care provided in state-operated facilities as provided under section
158.28 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

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

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

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

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

159.10 (7) new foster care licenses or community residential setting licenses for people receiving
159.11 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
159.12 for which a license is required. This exception does not apply to people living in their own
159.13 home. For purposes of this clause, there is a presumption that a foster care or community
159.14 residential setting license is required for services provided to three or more people in a
159.15 dwelling unit when the setting is controlled by the provider. A license holder subject to this
159.16 exception may rebut the presumption that a license is required by seeking a reconsideration
159.17 of the commissioner's determination. The commissioner's disposition of a request for
159.18 reconsideration is final and not subject to appeal under chapter 14. The exception is available
159.19 until June 30, ~~2018~~ 2019. This exception is available when:

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

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

159.26 (8) a vacancy in a setting granted an exception under clause (7), created between January
159.27 1, 2017, and the date of the exception request, by the departure of a person receiving services
159.28 under chapter 245D and residing in the unlicensed setting between January 1, 2017, and
159.29 May 1, 2017. This exception is available when the lead agency provides documentation to
159.30 the commissioner on the eligibility criteria being met. This exception is available until June
159.31 30, 2019.

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

160.4 (c) When an adult resident ~~served by the program moves out of a~~ for any reason
160.5 permanently vacates a bed in an adult foster care home that is not the primary residence of
160.6 the license holder ~~according to section 256B.49, subdivision 15, paragraph (f)~~, or ~~the~~ a bed
160.7 in an adult community residential setting, the county shall immediately inform the
160.8 ~~Department of Human Services Licensing Division~~ commissioner. Within six months of
160.9 the second bed being permanently vacated, the ~~department may~~ commissioner shall decrease
160.10 the statewide licensed capacity for adult foster care settings by one bed for every two beds
160.11 vacated.

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

160.16 (e) A resource need determination process, managed at the state level, using the available
160.17 reports required by section 144A.351, and other data and information shall be used to
160.18 determine where the reduced capacity determined under section 256B.493 will be
160.19 implemented. The commissioner shall consult with the stakeholders described in section
160.20 144A.351, and employ a variety of methods to improve the state's capacity to meet the
160.21 informed decisions of those people who want to move out of corporate foster care or
160.22 community residential settings, long-term service needs within budgetary limits, including
160.23 seeking proposals from service providers or lead agencies to change service type, capacity,
160.24 or location to improve services, increase the independence of residents, and better meet
160.25 needs identified by the long-term services and supports reports and statewide data and
160.26 information.

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

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

161.7 (h) The commissioner may adjust capacity to address needs identified in section
161.8 144A.351. Under this authority, the commissioner may approve new licensed settings or
161.9 delicense existing settings. Delicensing of settings will be accomplished through a process
161.10 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
161.11 information and data on capacity of licensed long-term services and supports, actions taken
161.12 under the subdivision to manage statewide long-term services and supports resources, and
161.13 any recommendations for change to the legislative committees with jurisdiction over the
161.14 health and human services budget.

161.15 (i) The commissioner must notify a license holder when its corporate foster care or
161.16 community residential setting licensed beds are reduced under this section. The notice of
161.17 reduction of licensed beds must be in writing and delivered to the license holder by certified
161.18 mail or personal service. The notice must state why the licensed beds are reduced and must
161.19 inform the license holder of its right to request reconsideration by the commissioner. The
161.20 license holder's request for reconsideration must be in writing. If mailed, the request for
161.21 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
161.22 after the license holder's receipt of the notice of reduction of licensed beds. If a request for

161.23 reconsideration is made by personal service, it must be received by the commissioner within
161.24 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

162.1 **EFFECTIVE DATE.** This section is effective July 1, 2019, except the amendment to
162.2 paragraph (a) adding clause (8) is effective retroactively from July 1, 2018, and applies to
162.3 exception requests made on or after that date.

162.4 Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

162.5 Subd. 2a. **Adult foster care and community residential setting license capacity.** (a)
162.6 The commissioner shall issue adult foster care and community residential setting licenses
162.7 with a maximum licensed capacity of four beds, including nonstaff roomers and boarders,
162.8 except that the commissioner may issue a license with a capacity of ~~five~~ up to six beds,
162.9 including roomers and boarders, according to paragraphs (b) to (g).

162.10 (b) The license holder may have a maximum license capacity of five if all persons in
162.11 care are age 55 or over and do not have a serious and persistent mental illness or a
162.12 developmental disability.

162.13 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
162.14 licensed capacity of up to five persons to admit an individual under the age of 55 if the
162.15 variance complies with section 245A.04, subdivision 9, and approval of the variance is
162.16 recommended by the county in which the licensed facility is located.

162.17 (d) The commissioner may grant variances to paragraph (a) to allow the use of an
162.18 additional bed, up to five, for emergency crisis services for a person with serious and
162.19 persistent mental illness or a developmental disability, regardless of age, if the variance
162.20 complies with section 245A.04, subdivision 9, and approval of the variance is recommended
162.21 by the county in which the licensed facility is located.

162.22 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of an
162.23 additional bed, up to five, for respite services, as defined in section 245A.02, for persons
162.24 with disabilities, regardless of age, if the variance complies with sections 245A.03,
162.25 subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended
162.26 by the county in which the licensed facility is located. Respite care may be provided under
162.27 the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of ~~five~~ six adults if the fifth ~~bed does~~ and sixth beds do not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed or six-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

(g) ~~The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, 2019.~~ The commissioner shall allow a facility with an adult foster care license

Senate Language UEH2414-1

163.32 issued under paragraph (f) ~~before June 30, 2019,~~ to continue with a capacity of five or six
163.33 adults if the license holder continues to comply with the requirements in paragraph (f).

House Language H2414-2

247.8 Sec. 11. Minnesota Statutes 2018, section 245C.03, is amended by adding a subdivision
247.9 to read:

247.10 Subd. 13. **Early intensive developmental and behavioral intervention providers.** The
247.11 commissioner shall conduct background studies according to this chapter when initiated by
247.12 an early intensive developmental and behavioral intervention provider under section
247.13 256B.0949.

247.14 Sec. 12. Minnesota Statutes 2018, section 245C.10, is amended by adding a subdivision
247.15 to read:

247.16 Subd. 14. **Early intensive developmental and behavioral intervention providers.** The
247.17 commissioner shall recover the cost of background studies required under section 245C.03,
247.18 subdivision 13, for the purposes of early intensive developmental and behavioral intervention
247.19 under section 256B.0949, through a fee of no more than $32 per study charged to the enrolled
247.20 agency. Fees collected under this subdivision are appropriated to the commissioner for the
247.21 purpose of conducting background studies.

247.22 Sec. 13. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

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

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

Senate Language UEH2414-1

164.1 Sec. 3. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

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

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

164.10 (1) in-home and out-of-home respite care services as defined in section 245A.02,
164.11 subdivision 15, and under the brain injury, community alternative care, community access
164.12 for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans,
164.13 excluding out-of-home respite care provided to children in a family child foster care home
164.14 licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care
164.15 license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7,
164.16 and 8, or successor provisions; and section 245D.061 or successor provisions, which must
164.17 be stipulated in the statement of intended use required under Minnesota Rules, part
164.18 2960.3000, subpart 4;

164.19 (2) adult companion services as defined under the brain injury, community access for
164.20 disability inclusion, community alternative care, and elderly waiver plans, excluding adult
164.21 companion services provided under the Corporation for National and Community Services

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	164.22 Senior Companion Program established under the Domestic Volunteer Service Act of 1973, 164.23 Public Law 98-288;
248.14 (3) personal support as defined under the developmental disability waiver plan;	164.24 (3) personal support as defined under the developmental ~~disability~~ disabilities waiver 164.25 plan;
248.15 (4) 24-hour emergency assistance, personal emergency response as defined under the 248.16 community access for disability inclusion and developmental disability waiver plans;	164.26 (4) 24-hour emergency assistance, personal emergency response as defined under the 164.27 community access for disability inclusion and developmental ~~disability~~ disabilities waiver 164.28 plans;
248.17 (5) night supervision services as defined under the brain injury waiver plan;	164.29 (5) night supervision services as defined under the brain injury, community access for 164.30 disability inclusion, community alternative care, and developmental disabilities waiver ~~plan~~ 164.31 plans;
248.18 (6) homemaker services as defined under the community access for disability inclusion, 248.19 brain injury, community alternative care, developmental disability, and elderly waiver plans, 248.20 excluding providers licensed by the Department of Health under chapter 144A and those 248.21 providers providing cleaning services only; ~~and~~	164.32 (6) homemaker services as defined under the community access for disability inclusion, 164.33 brain injury, community alternative care, developmental ~~disability~~ disabilities, and elderly 165.1 waiver plans, excluding providers licensed by the Department of Health under chapter 144A 165.2 and those providers providing cleaning services only; and
248.22 (7) individual community living support under section 256B.0915, subdivision 3j~~.~~; and	165.3 (7) individual community living support under section 256B.0915, subdivision 3j.
248.23 (8) individualized home supports services as defined under the brain injury, community 248.24 alternative care, and community access for disability inclusion, and developmental disability 248.25 waiver plans.	
248.26 (c) Intensive support services provide assistance, supervision, and care that is necessary 248.27 to ensure the health and welfare of the person and services specifically directed toward the 248.28 training, habilitation, or rehabilitation of the person. Intensive support services include:	165.4 (c) Intensive support services provide assistance, supervision, and care that is necessary 165.5 to ensure the health and welfare of the person and services specifically directed toward the 165.6 training, habilitation, or rehabilitation of the person. Intensive support services include:
248.29 (1) intervention services, including:	165.7 (1) intervention services, including:
248.30 (i) behavioral support services as defined under the brain injury and community access 248.31 for disability inclusion waiver plans;	165.8 (i) ~~behavioral~~ positive support services as defined under the brain injury and community 165.9 access for disability inclusion, community alternative care, and developmental disabilities 165.10 waiver plans;
249.1 (ii) in-home or out-of-home crisis respite services as defined under the developmental 249.2 disability waiver plan; and	165.11 (ii) in-home or out-of-home crisis respite services as defined under the brain injury, 165.12 community access for disability inclusion, community alternative care, and developmental 165.13 ~~disability~~ disabilities waiver ~~plan~~ plans; and
249.3 (iii) specialist services as defined under the current developmental disability waiver 249.4 plan;	165.14 (iii) specialist services as defined under the current brain injury, community access for 165.15 disability inclusion, community alternative care, and developmental ~~disability~~ disabilities 165.16 waiver ~~plan~~ plans;
249.5 (2) in-home support services, including:	165.17 (2) in-home support services, including:
249.6 (i) in-home family support and supported living services as defined under the 249.7 developmental disability waiver plan;	165.18 (i) in-home family support and supported living services as defined under the 165.19 developmental ~~disability~~ disabilities waiver plan;

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249.8 (ii) independent living services training as defined under the brain injury and community 249.9 access for disability inclusion waiver plans;	165.20 (ii) independent living services training as defined under the brain injury and community 165.21 access for disability inclusion waiver plans;
249.10 (iii) semi-independent living services; ~~and~~	165.22 (iii) semi-independent living services; and
249.11 ~~(iv) individualized home supports services as defined under the brain injury, community~~ 249.12 ~~alternative care, and community access for disability inclusion waiver plans;~~	165.23 (iv) individualized home supports services as defined under the brain injury, community 165.24 alternative care, and community access for disability inclusion waiver plans;
249.13 (iv) individualized home support with training services as defined under the brain injury, 249.14 community alternative care, community access for disability inclusion, and developmental 249.15 disability waiver plans; and	
249.16 (v) individualized home support with family training services as defined under the brain 249.17 injury, community alternative care, community access for disability inclusion, and 249.18 developmental disability waiver plans;	
249.19 (3) residential supports and services, including:	165.25 (3) residential supports and services, including:
249.20 (i) supported living services as defined under the developmental disability waiver plan 249.21 provided in a family or corporate child foster care residence, a family adult foster care 249.22 residence, a community residential setting, or a supervised living facility;	165.26 (i) supported living services as defined under the developmental ~~disability~~ disabilities 165.27 waiver plan provided in a family or corporate child foster care residence, a family adult 165.28 foster care residence, a community residential setting, or a supervised living facility;
249.23 (ii) foster care services as defined in the brain injury, community alternative care, and 249.24 community access for disability inclusion waiver plans provided in a family or corporate 249.25 child foster care residence, a family adult foster care residence, or a community residential 249.26 setting; ~~and~~	165.29 (ii) foster care services as defined in the brain injury, community alternative care, and 165.30 community access for disability inclusion waiver plans provided in a family or corporate 166.1 child foster care residence, a family adult foster care residence, or a community residential 166.2 setting; and
249.27 (iii) community residential services as defined under the brain injury, community 249.28 alternative care, community access for disability inclusion, and developmental disability 249.29 waiver plans provided in a corporate child foster care residence, a community residential 249.30 setting, or a supervised living facility;	
250.1 (iv) family residential services as defined in the brain injury, community alternative 250.2 care, community access for disability inclusion, and developmental disability waiver plans 250.3 provided in a family child foster care residence or a family adult foster care residence; and	
250.4 (v) residential services provided to more than four persons with developmental disabilities 250.5 in a supervised living facility, including ICFs/DD;	166.3 (iii) residential services provided to more than four persons with developmental 166.4 disabilities in a supervised living facility, including ICFs/DD;
250.6 (4) day services, including:	166.5 (4) day services, including:
250.7 (i) structured day services as defined under the brain injury waiver plan;	166.6 (i) structured day services as defined under the brain injury waiver plan;
250.8 (ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, 250.9 community alternative care, community access for disability inclusion, and developmental 250.10 disability waiver plans;	
250.11 (iii) day training and habilitation services under sections 252.41 to 252.46, and as defined 250.12 under the developmental disability waiver plan; and	166.7 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined 166.8 under the developmental ~~disability~~ disabilities waiver plan; and

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250.13 (iii) (iv) prevocational services as defined under the brain injury and, community
250.14 alternative care, community access for disability inclusion, and developmental disability
250.15 waiver plans; and

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

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

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

250.25 (8) integrated community support as defined under the brain injury and community
250.26 access for disability inclusion waiver plans beginning January 1, 2021, and community
250.27 alternative care and developmental disability waiver plans beginning January 1, 2023.

250.28 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
250.29 whichever is later. The commissioner of human services shall notify the revisor of statutes
250.30 when federal approval is obtained.

251.1 Sec. 14. Minnesota Statutes 2018, section 245D.071, subdivision 1, is amended to read:

251.2 Subdivision 1. **Requirements for intensive support services.** Except for services
251.3 identified in section 245D.03, subdivision 1, paragraph (c), clauses (1) and (2), item (ii), a
251.4 license holder providing intensive support services identified in section 245D.03, subdivision
251.5 1, paragraph (c), must comply with the requirements in this section and section 245D.07,
251.6 subdivisions 1, 1a, and 3. Services identified in section 245D.03, subdivision 1, paragraph
251.7 (c), clauses (1) and (2), item (ii), must comply with the requirements in section 245D.07,
251.8 subdivision 2.

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

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

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

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

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

166.20 Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

166.21 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
166.22 person or the person's legal representative and case manager an opportunity to participate
166.23 in the ongoing review and development of the service plan and the methods used to support
166.24 the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per
166.25 year, or within 30 days of a written request by the person, the person's legal representative,
166.26 or the case manager, the license holder, in coordination with the person's support team or
166.27 expanded support team, must meet with the person, the person's legal representative, and
166.28 the case manager, and participate in service plan review meetings following stated timelines

166.29 established in the person's coordinated service and support plan or coordinated service and
166.30 support plan addendum ~~or within 30 days of a written request by the person, the person's~~
166.31 ~~legal representative, or the case manager, at a minimum of once per year~~. The purpose of
166.32 the service plan review is to determine whether changes are needed to the service plan based
167.1 on the assessment information, the license holder's evaluation of progress towards
167.2 accomplishing outcomes, or other information provided by the support team or expanded
167.3 support team.

167.4 (b) At least once per year, the license holder, in coordination with the person's support
167.5 team or expanded support team, must meet with the person, the person's legal representative,
167.6 and the case manager to discuss how technology might be used to meet the person's desired
167.7 outcomes. The coordinated service and support plan addendum must include a summary of
167.8 this discussion. The summary must include a statement regarding any decision made related
167.9 to the use of technology and a description of any further research that must be completed
167.10 before a decision regarding the use of technology can be made. Nothing in this paragraph
167.11 requires the coordinated service and support plan addendum to include the use of technology
167.12 for the provision of services.

167.13 ~~(b)~~ (c) The license holder must summarize the person's status and progress toward
167.14 achieving the identified outcomes and make recommendations and identify the rationale
167.15 for changing, continuing, or discontinuing implementation of supports and methods identified
167.16 in subdivision 4 in a report available at the time of the progress review meeting. The report
167.17 must be sent at least five working days prior to the progress review meeting if requested by
167.18 the team in the coordinated service and support plan or coordinated service and support
167.19 plan addendum.

167.20 ~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum
167.21 to the person, the person's legal representative, and the case manager by mail within ten
167.22 working days of the progress review meeting. Within ten working days of the mailing of
167.23 the coordinated service and support plan addendum, the license holder must obtain dated
167.24 signatures from the person or the person's legal representative and the case manager to
167.25 document approval of any changes to the coordinated service and support plan addendum.

167.26 ~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and
167.27 support plan and coordinated service and support plan addendum, the person or the person's
167.28 legal representative or case manager has not signed and returned to the license holder the
167.29 coordinated service and support plan or coordinated service and support plan addendum or
167.30 has not proposed written modifications to the license holder's submission, the submission
167.31 is deemed approved and the coordinated service and support plan addendum becomes
167.32 effective and remains in effect until the legal representative or case manager submits a
167.33 written request to revise the coordinated service and support plan addendum.

168.1 Sec. 5. Minnesota Statutes 2018, section 245D.09, subdivision 5, is amended to read:

168.2 Subd. 5. **Annual training.** A license holder must provide annual training to direct support
168.3 staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff

168.4 has a first aid certification, annual training under subdivision 4, clause (9), is not required
168.5 as long as the certification remains current. ~~A license holder must provide a minimum of~~
168.6 ~~24 hours of annual training to direct service staff providing intensive services and having~~
168.7 ~~fewer than five years of documented experience and 12 hours of annual training to direct~~
168.8 ~~service staff providing intensive services and having five or more years of documented~~
168.9 ~~experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on~~
168.10 ~~relevant topics received from sources other than the license holder may count toward training~~
168.11 ~~requirements. A license holder must provide a minimum of 12 hours of annual training to~~
168.12 ~~direct service staff providing basic services and having fewer than five years of documented~~
168.13 ~~experience and six hours of annual training to direct service staff providing basic services~~
168.14 ~~and having five or more years of documented experience.~~

168.15 Sec. 6. Minnesota Statutes 2018, section 245D.09, subdivision 5a, is amended to read:

168.16 Subd. 5a. **Alternative sources of training.** ~~The commissioner may approve online~~
168.17 ~~training and competency-based assessments in place of a specific number of hours of training~~
168.18 ~~in the topics covered in subdivision 4. The commissioner must provide a list of preapproved~~
168.19 ~~trainings that do not need approval for each individual license holder.~~

168.20 Orientation or training received by the staff person from sources other than the license
168.21 holder in the same subjects as identified in subdivision 4 may count toward the orientation
168.22 and annual training requirements if received in the 12-month period before the staff person's
168.23 date of hire. The license holder must maintain documentation of the training received from
168.24 other sources and of each staff person's competency in the required area according to the
168.25 requirements in subdivision 3.

168.26 Sec. 7. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

168.27 Subd. 2. **~~Behavior~~ Positive support professional qualifications.** A ~~behavior~~ positive
168.28 support professional providing ~~behavioral~~ positive support services as identified in section
168.29 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
168.30 following areas as required under the brain injury ~~and~~, community access for disability
168.31 inclusion, community alternative care, and developmental disabilities waiver plans or
168.32 successor plans:

168.33 (1) ethical considerations;

169.1 (2) functional assessment;

169.2 (3) functional analysis;

169.3 (4) measurement of behavior and interpretation of data;

169.4 (5) selecting intervention outcomes and strategies;

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

169.7 (7) data collection;

169.8 (8) staff and caregiver training;

169.9 (9) support plan monitoring;

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

169.11 (11) demonstrated expertise with populations being served; and

169.12 (12) must be a:

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

169.15 (ii) clinical social worker licensed as an independent clinical social worker under chapter
169.16 148D, or a person with a master's degree in social work from an accredited college or
169.17 university, with at least 4,000 hours of post-master's supervised experience in the delivery
169.18 of clinical services in the areas identified in clauses (1) to (11);

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

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

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

169.29 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
169.30 fields with demonstrated expertise in positive support services; or

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

170.7 Sec. 8. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

170.8 Subd. 3. **~~Behavior~~ Positive support analyst qualifications.** (a) A ~~behavior~~ positive
170.9 support analyst providing ~~behavioral~~ positive support services as identified in section
170.10 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
170.11 following areas as required under the brain injury ~~and~~, community access for disability

170.12 inclusion, community alternative care, and developmental disabilities waiver plans or
170.13 successor plans:

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

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

170.18 (3) be a board-certified behavior analyst or board-certified assistant behavior analyst by
170.19 the Behavior Analyst Certification Board, Incorporated.

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

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

170.26 (2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~
170.27 training prior to hire or within 90 calendar days of hire that includes:

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

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

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

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

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

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

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

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

171.10 ~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training
171.11 and prerequisite skills required to provide positive practice strategies as well as behavior
171.12 reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive
171.13 support; and

171.14 ~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

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

171.17 Sec. 9. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

171.18 Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive
171.19 support specialist providing ~~behavioral~~ positive support services as identified in section
171.20 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
171.21 following areas as required under the brain injury ~~and~~, community access for disability
171.22 inclusion, community alternative care, and developmental disabilities waiver plans or
171.23 successor plans:

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

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

171.27 (b) In addition, a behavior specialist must:

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

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

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

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

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

172.4 ~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training
172.5 and prerequisite skills required to provide positive practices strategies as well as behavior
172.6 reduction approved intervention to the person who receives ~~behavioral~~ positive support;
172.7 and

172.8 ~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

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

251.10 Sec. 15. [245D.12] INTEGRATED COMMUNITY SUPPORTS; SETTING
251.11 CAPACITY REPORT.

251.12 (a) The license holder providing integrated community support, as defined in section
251.13 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to

251.14 the commissioner to ensure the identified location of service delivery meets the criteria of
251.15 the home and community-based service requirements as specified in section 256B.492.

251.16 (b) The license holder shall provide the setting capacity report on the forms and in the
251.17 manner prescribed by the commissioner. The report must include:

251.18 (1) the address of the multifamily housing building where the license holder delivers
251.19 integrated community supports and owns, leases, or has a direct or indirect financial
251.20 relationship with the property owner;

251.21 (2) the total number of living units in the multifamily housing building described in
251.22 clause (1) where integrated community supports are delivered;

251.23 (3) the total number of living units in the multifamily housing building described in
251.24 clause (1), including the living units identified in clause (2); and

251.25 (4) the percentage of living units that are controlled by the license holder in the
251.26 multifamily housing building by dividing clause (2) by clause (3).

251.27 (c) Only one license holder may deliver integrated community supports at the address
251.28 of the multifamily housing building.

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

252.1 Sec. 16. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

252.2 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
252.3 including a child determined eligible for medical assistance without consideration of parental
252.4 income, must contribute to the cost of services used by making monthly payments on a
252.5 sliding scale based on income, unless the child is married or has been married, parental
252.6 rights have been terminated, or the child's adoption is subsidized according to chapter 259A
252.7 or through title IV-E of the Social Security Act. The parental contribution is a partial or full
252.8 payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating,
252.9 rehabilitation, maintenance, and personal care services as defined in United States Code,
252.10 title 26, section 213, needed by the child with a chronic illness or disability.

252.11 (b) For households with adjusted gross income equal to or greater than 275 percent of
252.12 federal poverty guidelines, the parental contribution shall be computed by applying the
252.13 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

252.14 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
252.15 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
252.16 contribution shall be determined using a sliding fee scale established by the commissioner
252.17 of human services which begins at ~~1.94~~ 1.65 percent of adjusted gross income at 275 percent

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104.24 Sec. 31. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

104.25 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
104.26 including a child determined eligible for medical assistance without consideration of parental
104.27 income, must contribute to the cost of services used by making monthly payments on a
104.28 sliding scale based on income, unless the child is married or has been married, parental
104.29 rights have been terminated, or the child's adoption is subsidized according to chapter 259A
104.30 or through title IV-E of the Social Security Act. The parental contribution is a partial or full
104.31 payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating,
104.32 rehabilitation, maintenance, and personal care services as defined in United States Code,
104.33 title 26, section 213, needed by the child with a chronic illness or disability.

105.1 (b) For households with adjusted gross income equal to or greater than 275 percent of
105.2 federal poverty guidelines, the parental contribution shall be computed by applying the
105.3 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

105.4 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
105.5 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
105.6 contribution shall be determined using a sliding fee scale established by the commissioner
105.7 of human services which begins at 1.94 percent of adjusted gross income at 275 percent of

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252.18 of federal poverty guidelines and increases to ~~5.29~~ 4.5 percent of adjusted gross income for
252.19 those with adjusted gross income up to 545 percent of federal poverty guidelines;

252.20 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
252.21 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
252.22 ~~5.29~~ 4.5 percent of adjusted gross income;

252.23 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
252.24 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
252.25 shall be determined using a sliding fee scale established by the commissioner of human
252.26 services which begins at ~~5.29~~ 4.5 percent of adjusted gross income at 675 percent of federal
252.27 poverty guidelines and increases to ~~7.05~~ 5.99 percent of adjusted gross income for those
252.28 with adjusted gross income up to 975 percent of federal poverty guidelines; and

252.29 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
252.30 guidelines, the parental contribution shall be ~~8.81~~ 7.49 percent of adjusted gross income.

252.31 If the child lives with the parent, the annual adjusted gross income is reduced by $2,400
252.32 prior to calculating the parental contribution. If the child resides in an institution specified
252.33 in section 256B.35, the parent is responsible for the personal needs allowance specified
252.34 under that section in addition to the parental contribution determined under this section.
253.1 The parental contribution is reduced by any amount required to be paid directly to the child
253.2 pursuant to a court order, but only if actually paid.

253.3 (c) The household size to be used in determining the amount of contribution under
253.4 paragraph (b) includes natural and adoptive parents and their dependents, including the
253.5 child receiving services. Adjustments in the contribution amount due to annual changes in
253.6 the federal poverty guidelines shall be implemented on the first day of July following
253.7 publication of the changes.

253.8 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
253.9 natural or adoptive parents determined according to the previous year's federal tax form,
253.10 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
253.11 have been used to purchase a home shall not be counted as income.

253.12 (e) The contribution shall be explained in writing to the parents at the time eligibility
253.13 for services is being determined. The contribution shall be made on a monthly basis effective
253.14 with the first month in which the child receives services. Annually upon redetermination
253.15 or at termination of eligibility, if the contribution exceeded the cost of services provided,
253.16 the local agency or the state shall reimburse that excess amount to the parents, either by
253.17 direct reimbursement if the parent is no longer required to pay a contribution, or by a
253.18 reduction in or waiver of parental fees until the excess amount is exhausted. All
253.19 reimbursements must include a notice that the amount reimbursed may be taxable income
253.20 if the parent paid for the parent's fees through an employer's health care flexible spending
253.21 account under the Internal Revenue Code, section 125, and that the parent is responsible
253.22 for paying the taxes owed on the amount reimbursed.

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105.8 federal poverty guidelines and increases to 5.29 percent of adjusted gross income for those
105.9 with adjusted gross income up to 545 percent of federal poverty guidelines;

105.10 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
105.11 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
105.12 5.29 percent of adjusted gross income;

105.13 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
105.14 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
105.15 shall be determined using a sliding fee scale established by the commissioner of human
105.16 services which begins at 5.29 percent of adjusted gross income at 675 percent of federal
105.17 poverty guidelines and increases to 7.05 percent of adjusted gross income for those with
105.18 adjusted gross income up to 975 percent of federal poverty guidelines; and

105.19 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
105.20 guidelines, the parental contribution shall be 8.81 percent of adjusted gross income.

105.21 If the child lives with the parent, the annual adjusted gross income is reduced by $2,400
105.22 prior to calculating the parental contribution. If the child resides in an institution specified
105.23 in section 256B.35, the parent is responsible for the personal needs allowance specified
105.24 under that section in addition to the parental contribution determined under this section.
105.25 The parental contribution is reduced by any amount required to be paid directly to the child
105.26 pursuant to a court order, but only if actually paid.

105.27 (c) The household size to be used in determining the amount of contribution under
105.28 paragraph (b) includes natural and adoptive parents and their dependents, including the
105.29 child receiving services. Adjustments in the contribution amount due to annual changes in
105.30 the federal poverty guidelines shall be implemented on the first day of July following
105.31 publication of the changes.

105.32 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
105.33 natural or adoptive parents determined according to the previous year's federal tax form,
106.1 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
106.2 have been used to purchase a home shall not be counted as income.

106.3 (e) The contribution shall be explained in writing to the parents at the time eligibility
106.4 for services is being determined. The contribution shall be made on a monthly basis effective
106.5 with the first month in which the child receives services. Annually upon redetermination
106.6 or at termination of eligibility, if the contribution exceeded the cost of services provided,
106.7 the local agency or the state shall reimburse that excess amount to the parents, either by
106.8 direct reimbursement if the parent is no longer required to pay a contribution, or by a
106.9 reduction in or waiver of parental fees until the excess amount is exhausted. All
106.10 reimbursements must include a notice that the amount reimbursed may be taxable income
106.11 if the parent paid for the parent's fees through an employer's health care flexible spending
106.12 account under the Internal Revenue Code, section 125, and that the parent is responsible
106.13 for paying the taxes owed on the amount reimbursed.

253.23 (f) The monthly contribution amount must be reviewed at least every 12 months; when
253.24 there is a change in household size; and when there is a loss of or gain in income from one
253.25 month to another in excess of ten percent. The local agency shall mail a written notice 30
253.26 days in advance of the effective date of a change in the contribution amount. A decrease in
253.27 the contribution amount is effective in the month that the parent verifies a reduction in
253.28 income or change in household size.

253.29 (g) Parents of a minor child who do not live with each other shall each pay the
253.30 contribution required under paragraph (a). An amount equal to the annual court-ordered
253.31 child support payment actually paid on behalf of the child receiving services shall be deducted
253.32 from the adjusted gross income of the parent making the payment prior to calculating the
253.33 parental contribution under paragraph (b).

254.1 (h) The contribution under paragraph (b) shall be increased by an additional five percent
254.2 if the local agency determines that insurance coverage is available but not obtained for the
254.3 child. For purposes of this section, "available" means the insurance is a benefit of employment
254.4 for a family member at an annual cost of no more than five percent of the family's annual
254.5 income. For purposes of this section, "insurance" means health and accident insurance
254.6 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
254.7 self-insured plan, or preferred provider organization.

254.8 Parents who have more than one child receiving services shall not be required to pay
254.9 more than the amount for the child with the highest expenditures. There shall be no resource
254.10 contribution from the parents. The parent shall not be required to pay a contribution in
254.11 excess of the cost of the services provided to the child, not counting payments made to
254.12 school districts for education-related services. Notice of an increase in fee payment must
254.13 be given at least 30 days before the increased fee is due.

254.14 (i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in
254.15 the 12 months prior to July 1:

254.16 (1) the parent applied for insurance for the child;

254.17 (2) the insurer denied insurance;

254.18 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
254.19 complaint or appeal, in writing, to the commissioner of health or the commissioner of
254.20 commerce, or litigated the complaint or appeal; and

254.21 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

254.22 For purposes of this section, "insurance" has the meaning given in paragraph (h).

254.23 A parent who has requested a reduction in the contribution amount under this paragraph
254.24 shall submit proof in the form and manner prescribed by the commissioner or county agency,
254.25 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
254.26 of the parents, court documents, and the written response of the insurer approving insurance.

106.14 (f) The monthly contribution amount must be reviewed at least every 12 months; when
106.15 there is a change in household size; and when there is a loss of or gain in income from one
106.16 month to another in excess of ten percent. The local agency shall mail a written notice 30
106.17 days in advance of the effective date of a change in the contribution amount. A decrease in
106.18 the contribution amount is effective in the month that the parent verifies a reduction in
106.19 income or change in household size.

106.20 (g) Parents of a minor child who do not live with each other shall each pay the
106.21 contribution required under paragraph (a). An amount equal to the annual court-ordered
106.22 child support payment actually paid on behalf of the child receiving services shall be deducted
106.23 from the adjusted gross income of the parent making the payment prior to calculating the
106.24 parental contribution under paragraph (b).

106.25 (h) The contribution under paragraph (b) shall be increased by an additional five percent
106.26 if the local agency determines that insurance coverage is available but not obtained for the
106.27 child. For purposes of this section, "available" means the insurance is a benefit of employment
106.28 for a family member at an annual cost of no more than five percent of the family's annual
106.29 income. For purposes of this section, "insurance" means health and accident insurance
106.30 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
106.31 self-insured plan, or preferred provider organization.

106.32 Parents who have more than one child receiving services shall not be required to pay
106.33 more than the amount for the child with the highest expenditures. There shall be no resource
106.34 contribution from the parents. The parent shall not be required to pay a contribution in
107.1 excess of the cost of the services provided to the child, not counting payments made to
107.2 school districts for education-related services. Notice of an increase in fee payment must
107.3 be given at least 30 days before the increased fee is due.

107.4 (i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in
107.5 the 12 months prior to July 1:

107.6 (1) the parent applied for insurance for the child;

107.7 (2) the insurer denied insurance;

107.8 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
107.9 complaint or appeal, in writing, to the commissioner of health or the commissioner of
107.10 commerce, or litigated the complaint or appeal; and

107.11 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

107.12 For purposes of this section, "insurance" has the meaning given in paragraph (h).

107.13 A parent who has requested a reduction in the contribution amount under this paragraph
107.14 shall submit proof in the form and manner prescribed by the commissioner or county agency,
107.15 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
107.16 of the parents, court documents, and the written response of the insurer approving insurance.

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254.27 The determinations of the commissioner or county agency under this paragraph are not rules
254.28 subject to chapter 14.

254.29 Sec. 17. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

254.30 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
254.31 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
254.32 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
255.1 for any person if the costs exceed the state share of the average medical assistance costs for
255.2 services provided by intermediate care facilities for a person with a developmental disability
255.3 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
255.4 person if the costs exceed $1,500 in a state fiscal year. The commissioner may make
255.5 payments to each county in quarterly installments. The commissioner may certify an advance
255.6 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
255.7 basis for reported expenditures and may be adjusted for anticipated spending patterns.

255.8 **EFFECTIVE DATE.** This section is effective July 1, 2019.

255.9 Sec. 18. Minnesota Statutes 2018, section 252.28, subdivision 1, is amended to read:

255.10 Subdivision 1. **Determinations; ~~redeterminations~~.** In conjunction with the appropriate
255.11 ~~county~~ lead agency boards, the commissioner of human services shall determine~~, and shall~~
255.12 ~~redetermine at least every four years,~~ the need, ~~anticipated~~ growth ~~or~~, decline in need ~~until~~
255.13 ~~the next anticipated redetermination~~, location, size, and program services of public and
255.14 private day training and habilitation services ~~for persons with developmental disabilities~~,
255.15 structured day services, prevocational services, and adult day services for people with
255.16 disabilities funded under medical assistance and the home and community-based services
255.17 waivers under sections 256B.092 and 256B.49. This subdivision does not apply to
255.18 semi-independent living services and residential-based habilitation services provided to
255.19 four or fewer persons at a single site funded as home and community-based services. A
255.20 determination of need shall not be required for a change in ownership.

255.21 Sec. 19. Minnesota Statutes 2018, section 252.41, subdivision 3, is amended to read:

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107.17 The determinations of the commissioner or county agency under this paragraph are not rules
107.18 subject to chapter 14.

107.19 (j) For the biennium ending June 30, 2020, the commissioner shall reduce the parental
107.20 contribution amount under paragraph (a) for natural or adoptive parents of a minor child
107.21 determined eligible for medical assistance without consideration of parental income under
107.22 the TEFRA option, or for the purposes of accessing home and community-based waiver
107.23 services, by an amount equal to a total general fund revenue reduction of $14,609,000.

107.24 (k) Beginning July 1, 2021, the natural or adoptive parents of a minor child determined
107.25 eligible for medical assistance without consideration of parental income under the TEFRA
107.26 option, or for the purposes of accessing home and community-based waiver services, shall
107.27 not be required to pay the parental contribution under paragraph (a).

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172.11 Sec. 10. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

172.12 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
172.13 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
172.14 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
172.15 for any person if the costs exceed the state share of the average medical assistance costs for
172.16 services provided by intermediate care facilities for a person with a developmental disability
172.17 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
172.18 person if the costs exceed $1,500 in a state fiscal year. The commissioner may make
172.19 payments to each county in quarterly installments. The commissioner may certify an advance
172.20 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
172.21 basis for reported expenditures and may be adjusted for anticipated spending patterns.

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

255.25 (1) include supervision, training, assistance, support, center-based facility-based
255.26 work-related activities, or other community-integrated activities designed and implemented
255.27 in accordance with the individual service and individual habilitation plans coordinated
255.28 service and support plan and coordinated service and support plan addendum required under
255.29 sections 245D.02, subdivision 4, paragraphs (b) and (c), and 256B.092, subdivision 1b, and
255.30 Minnesota Rules, parts part 9525.0004 to 9525.0036, subpart 12, to help an adult reach and
255.31 maintain the highest possible level of independence, productivity, and integration into the
255.32 community; and

256.1 (2) include day support services, prevocational services, day training and habilitation
256.2 services, structured day services, and adult day services as defined in Minnesota's federally
256.3 approved disability waiver plans; and

256.4 (3) are provided by a vendor licensed under sections 245A.01 to 245A.16 and, 245D.27
256.5 to 245D.31, 252.28, subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts
256.6 9525.1200 to 9525.1330, to provide day training and habilitation services.

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

256.12 (c) Day training and habilitation services do not include employment exploration,
256.13 employment development, or employment support services as defined in the home and
256.14 community-based services waivers for people with disabilities authorized under sections
256.15 256B.092 and 256B.49.

256.16 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
256.17 whichever is later. The commissioner of human services shall notify the revisor of statutes
256.18 when federal approval is obtained.

256.19 Sec. 20. Minnesota Statutes 2018, section 252.41, subdivision 4, is amended to read:

256.20 Subd. 4. **Independence.** "Independence" means the extent to which persons with
256.21 developmental disabilities exert control and choice over their own lives.

256.22 **EFFECTIVE DATE.** This section is effective January 1, 2021.

256.23 Sec. 21. Minnesota Statutes 2018, section 252.41, subdivision 5, is amended to read:

256.24 Subd. 5. **Integration.** "Integration" means that persons with developmental disabilities:

256.25 (1) use the same community resources that are used by and available to individuals who
256.26 are not disabled;

256.27 (2) participate in the same community activities in which nondisabled individuals
256.28 participate; and

256.29 (3) regularly interact and have contact with nondisabled individuals.

256.30 **EFFECTIVE DATE.** This section is effective January 1, 2021.

257.1 Sec. 22. Minnesota Statutes 2018, section 252.41, subdivision 6, is amended to read:

257.2 Subd. 6. **Productivity.** "Productivity" means that persons with ~~developmental~~ disabilities:

257.3 (1) engage in income-producing work designed to improve their income level,
257.4 employment status, or job advancement; or

257.5 (2) engage in activities that contribute to a business, household, or community.

257.6 **EFFECTIVE DATE.** This section is effective January 1, 2021.

257.7 Sec. 23. Minnesota Statutes 2018, section 252.41, subdivision 7, is amended to read:

257.8 Subd. 7. **Regional center.** "Regional center" means any state-operated facility under
257.9 the direct administrative authority of the commissioner that serves persons with
257.10 ~~developmental~~ disabilities.

257.11 **EFFECTIVE DATE.** This section is effective January 1, 2021.

257.12 Sec. 24. Minnesota Statutes 2018, section 252.41, subdivision 9, is amended to read:

257.13 Subd. 9. **Vendor.** "Vendor" means a ~~nonprofit~~ legal entity that:

257.14 (1) is licensed under sections 245A.01 to 245A.16 ~~and~~, 245D.27 to 245D.31, 252.28,
257.15 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330,
257.16 to provide day ~~training and habilitation~~ services to adults with ~~developmental~~ disabilities;
257.17 and

257.18 (2) does not have a financial interest in the legal entity that provides residential services
257.19 to the same person or persons to whom it provides day ~~training and habilitation~~ services.
257.20 This clause does not apply to regional treatment centers, state-operated, community-based
257.21 programs operating according to section 252.50 until July 1, 2000, or vendors licensed prior
257.22 to April 15, 1983.

257.23 **EFFECTIVE DATE.** This section is effective January 1, 2021.

257.24 Sec. 25. Minnesota Statutes 2018, section 252.42, is amended to read:
257.25 252.42 SERVICE PRINCIPLES.

257.26 The design and delivery of services eligible for reimbursement should reflect the
257.27 following principles:

257.28 (1) services must suit a person's chronological age and be provided in the least restrictive
257.29 environment possible, consistent with the needs identified in the person's ~~individual service~~
258.1 ~~and individual habilitation plans under~~ coordinated service and support plan and coordinated
258.2 service and support plan addendum required under sections 256B.092, subdivision 1b, and
258.3 245D.02, subdivision 4, paragraphs (b) and (c), and Minnesota Rules, parts 9525.0004 ~~to~~
258.4 ~~9525.0036~~, subpart 12;

258.5 (2) a person with a ~~developmental~~ disability whose individual ~~service and individual~~
258.6 ~~habilitation plans~~ coordinated service and support plans and coordinated service and support
258.7 plan addendums authorize employment or employment-related activities shall be given the
258.8 opportunity to participate in employment and employment-related activities in which
258.9 nondisabled persons participate;

258.10 (3) a person with a ~~developmental~~ disability participating in work shall be paid wages
258.11 commensurate with the rate for comparable work and productivity except as regional centers
258.12 are governed by section 246.151;

258.13 (4) a person with a ~~developmental~~ disability shall receive services which include services
258.14 offered in settings used by the general public and designed to increase the person's active
258.15 participation in ordinary community activities;

258.16 (5) a person with a ~~developmental~~ disability shall participate in the patterns, conditions,
258.17 and rhythms of everyday living and working that are consistent with the norms of the
258.18 mainstream of society.

258.19 **EFFECTIVE DATE.** This section is effective January 1, 2021.

258.20 Sec. 26. Minnesota Statutes 2018, section 252.43, is amended to read:
258.21 252.43 COMMISSIONER'S DUTIES.

258.22 The commissioner shall supervise ~~county boards'~~ lead agencies' provision of day ~~training~~
258.23 ~~and habilitation~~ services to adults with ~~developmental~~ disabilities. The commissioner shall:

258.24 (1) determine the need for day ~~training and habilitation~~ services under section ~~252.28~~
258.25 256B.4914;

258.26 (2) establish payment rates as provided under section 256B.4914;

258.27 (3) add transportation costs to the day services payment rate;

258.28 (4) adopt rules for the administration and provision of day ~~training and habilitation~~
258.29 services under ~~sections 252.41 to 252.46 and~~ sections 245A.01 to 245A.16 ~~and~~, 252.28,
258.30 subdivision 2, and 252.41 to 252.46, and Minnesota Rules, parts 9525.1200 to 9525.1330;

259.1 ~~(4)~~ (5) enter into interagency agreements necessary to ensure effective coordination and
259.2 provision of day ~~training and habilitation~~ services;

259.3 ~~(5)~~ (6) monitor and evaluate the costs and effectiveness of day ~~training and habilitation~~
259.4 services; and

259.5 ~~(6)~~ (7) provide information and technical help to ~~county boards~~ lead agencies and vendors
259.6 in their administration and provision of day ~~training and habilitation~~ services.

259.7 **EFFECTIVE DATE.** This section is effective January 1, 2021.

259.8 Sec. 27. Minnesota Statutes 2018, section 252.44, is amended to read:
259.9 252.44 ~~COUNTY~~ LEAD AGENCY BOARD RESPONSIBILITIES.

259.10 When the need for day ~~training and habilitation~~ services in a county or tribe has been
259.11 determined under section 252.28, the board of commissioners for that ~~county~~ lead agency
259.12 shall:

259.13 (1) authorize the delivery of services according to the ~~individual service and habilitation~~
259.14 ~~plans~~ coordinated service and support plans and coordinated service and support plan
259.15 addendums required as part of the ~~county's~~ lead agency's provision of case management
259.16 services under sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092,
259.17 subdivision 1b; and 256B.49, subdivision 15, and Minnesota Rules, parts 9525.0004 to
259.18 9525.0036~~. For calendar years for which section 252.46, subdivisions 2 to 10, apply, the~~
259.19 ~~county board shall not authorize a change in service days from the number of days authorized~~
259.20 ~~for the previous calendar year unless there is documentation for the change in the individual~~
259.21 ~~service plan. An increase in service days must also be supported by documentation that the~~
259.22 ~~goals and objectives assigned to the vendor cannot be met more economically and effectively~~
259.23 ~~by other available community services and that without the additional days of service the~~
259.24 ~~individual service plan could not be implemented in a manner consistent with the service~~
259.25 ~~principles in section 252.42~~;

259.26 (2) ensure that transportation is provided or arranged by the vendor in the most efficient
259.27 and reasonable way possible; and

259.28 (3) monitor and evaluate the cost and effectiveness of the services.

259.29 **EFFECTIVE DATE.** This section is effective January 1, 2021.

260.1 Sec. 28. Minnesota Statutes 2018, section 252.45, is amended to read:
260.2 252.45 VENDOR'S DUTIES.

260.3 A day service vendor enrolled with the commissioner is responsible for items under
260.4 clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable
260.5 under state and federal law. A vendor providing day ~~training and habilitation~~ services shall:

260.6 (1) provide the amount and type of services authorized in the individual service plan
260.7 under coordinated service and support plan and coordinated service and support plan
260.8 addendum required under sections 245D.02, subdivision 4, paragraphs (b) and (c), and
260.9 256B.092, subdivision 1b, and Minnesota Rules, ~~parts~~ part 9525.0004 ~~to 9525.0036~~, subpart
260.10 12;

260.11 (2) design the services to achieve the outcomes assigned to the vendor in the ~~individual~~
260.12 ~~service plan~~ coordinated service and support plan and coordinated service and support plan

260.13 addendum required under sections 245D.02, subdivision 4, paragraphs (a) and (b), and
260.14 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

260.15 (3) provide or arrange for transportation of persons receiving services to and from service
260.16 sites;

260.17 (4) enter into agreements with community-based intermediate care facilities for persons
260.18 with developmental disabilities to ensure compliance with applicable federal regulations;
260.19 and

260.20 (5) comply with state and federal law.

260.21 **EFFECTIVE DATE.** This section is effective January 1, 2021.

ARTICLE 2:

107.28 Sec. 32. [256.4751] PARENT-TO-PARENT PEER SUPPORT GRANTS.

107.29 (a) The commissioner shall make available grants to organizations to support
107.30 parent-to-parent peer support programs that provide information and emotional support for
107.31 families of children and youth with special health care needs.

108.1 (b) For the purposes of this section, "special health care needs" means disabilities, chronic
108.2 illnesses or conditions, health-related educational or behavioral problems, or the risk of
108.3 developing disabilities, conditions, illnesses, or problems.

108.4 (c) Eligible organizations must have an established parent-to-parent program that:

108.5 (1) conducts outreach and support to parents or guardians of a child or youth with special
108.6 health care needs;

108.7 (2) provides to parents and guardians information, tools, and training to support their
108.8 child and to successfully navigate the health and human services systems;

108.9 (3) facilitates ongoing peer support for parents and guardians from trained volunteer
108.10 support parents;

108.11 (4) has staff and volunteers located statewide; and

108.12 (5) is affiliated with and communicates regularly with other parent-to-parent programs
108.13 and national organizations to ensure best practices are implemented.

108.14 (d) Grant recipients must use grant funds for the purposes in paragraph (c).

108.15 (e) Grant recipients must report to the commissioner of human services annually by
108.16 January 15 on the services and programs funded by the appropriation. The report must
108.17 include measurable outcomes from the previous year, including the number of families
108.18 served and the number of volunteer support parents trained.

ARTICLE 5:

172.22 Sec. 11. [256.488] ADAPTIVE FITNESS ACCESS GRANT.

172.23 Subdivision 1. **Definitions.** (a) "Adaptive fitness" means the practice of physical fitness
172.24 by an individual with primary physical disabilities, either as a consequence of the natural
172.25 aging process or due to a developmental disability, mental health issue, congenital condition,
172.26 trauma, injury, or disease.

172.27 (b) "Adaptive fitness center" means a center with modified equipment, equipment
172.28 arrangement and space for access, and trainers with skills in modifying exercise programs
172.29 specific to the physical and cognitive needs of individuals with disabilities.

172.30 (c) "Commissioner" means the commissioner of human services.

172.31 (d) "Disability" has the meaning given in the Americans with Disabilities Act.

173.1 Subd. 2. **Establishment.** A statewide adaptive fitness access grant program is established
173.2 under the Department of Human Services to award grants to promote access to adaptive
173.3 fitness for individuals with disabilities.

173.4 Subd. 3. **Application and review.** (a) The commissioner must develop a grant application
173.5 that must contain, at a minimum:

173.6 (1) a description of the purpose or project for which the grant will be used;

173.7 (2) a description of the specific problem the grant intends to address;

173.8 (3) a description of achievable objectives, a work plan, and a timeline for implementation
173.9 and completion of processes or projects enabled by the grant;

173.10 (4) a description of the existing frameworks and experience providing adaptive fitness;
173.11 and

173.12 (5) a proposed process for documenting and evaluating results of the grant.

173.13 (b) An applicant must apply using the grant application developed by the commissioner.

173.14 (c) The commissioner shall review each application. The commissioner shall establish
173.15 criteria to evaluate applications, including but not limited to:

173.16 (1) the application is complete;

173.17 (2) the eligibility of the applicant;

173.18 (3) the thoroughness and clarity in identifying the specific problem the grant intends to
173.19 address;

173.20 (4) a description of the population demographics and service area of the proposed project;

173.21 (5) documentation the grant applicant has received cash or in-kind contributions of value
173.22 equal to the requested grant amount; and

173.23 (6) the proposed project's longevity and demonstrated financial sustainability after the
173.24 initial grant period.

173.25 (d) In evaluating applications, the commissioner may request additional information
173.26 regarding a proposed project, including information on project cost. An applicant's failure
173.27 to timely provide the information requested disqualifies an applicant.

173.28 Subd. 4. **Awards.** (a) The commissioner shall award grants to eligible applicants to
173.29 provide adaptive fitness for individuals with disabilities.

174.1 (b) The commissioner shall award grants to qualifying nonprofit organizations that
174.2 provide adaptive fitness in adaptive fitness centers. Grants must be used to assist one or
174.3 more qualified nonprofit organizations to provide adaptive fitness, including: (1) stay fit;
174.4 (2) activity-based locomotor exercise; (3) equipment necessary for adaptive fitness programs;
174.5 (4) operating expenses related to staffing of adaptive fitness programs; and (5) other adaptive
174.6 fitness programs as deemed appropriate by the commissioner.

174.7 (c) An applicant may apply for and the commissioner may award grants for two-year
174.8 periods, and the commissioner shall determine the number of grants awarded. The
174.9 commissioner may reallocate underspending among grantees within the same grant period.

174.10 Subd. 5. **Report.** Beginning December 1, 2020, and every two years thereafter, the
174.11 commissioner of human services shall submit a report to the chairs and ranking minority
174.12 members of the legislative committees with jurisdiction over health and human services.
174.13 The report shall, at a minimum, include the amount of funding awarded for each project, a
174.14 description of the programs and services funded, plans for the long-term sustainability of
174.15 the projects, and data on outcomes for the programs and services funded. Grantees must
174.16 provide information and data requested by the commissioner to support the development
174.17 of this report.

ARTICLE 8:

260.22 Sec. 29. Minnesota Statutes 2018, section 256.9365, is amended to read:
260.23 256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR
260.24 ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.

260.25 Subdivision 1. **Program established.** The commissioner of human services shall establish
260.26 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
260.27 including co-payments, deductibles, and coinsurance for persons who have contracted human
260.28 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
260.29 group or individual health plan. If a person is determined to be eligible under subdivision
260.30 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
260.31 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
260.32 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription

267.12 Sec. 3. Minnesota Statutes 2018, section 256.9365, is amended to read:
267.13 256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR
267.14 ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.

267.15 Subdivision 1. **Program established.** The commissioner of human services shall establish
267.16 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
267.17 including co-payments, deductibles, and coinsurance for persons who have contracted human
267.18 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
267.19 group or individual health plan. If a person is determined to be eligible under subdivision
267.20 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
267.21 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
267.22 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription

261.1 cost sharing, including co-payments and deductibles required under section 256B.0631.
261.2 The commissioner shall not pay for that portion of a premium that is attributable to other
261.3 family members or dependents or is paid by the individual's employer.

261.4 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
261.5 satisfy the following requirements: meet all eligibility requirements for Part B of the Ryan
261.6 White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87, and enroll in the
261.7 Minnesota Ryan White program.

261.8 (1) the applicant must provide a physician's, advanced practice registered nurse's, or
261.9 physician assistant's statement verifying that the applicant is infected with HIV and is, or
261.10 within three months is likely to become, too ill to work in the applicant's current employment
261.11 because of HIV-related disease;

261.12 (2) the applicant's monthly gross family income must not exceed 300 percent of the
261.13 federal poverty guidelines, after deducting medical expenses and insurance premiums;

261.14 (3) the applicant must not own assets with a combined value of more than $25,000; and

261.15 (4) if applying for payment of group plan premiums, the applicant must be covered by
261.16 an employer's or former employer's group insurance plan.

261.17 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
261.18 premiums under subdivision 2, clause (5), must be designed to ensure that the state cost of
261.19 paying an individual plan premium does not exceed the estimated state cost that would
261.20 otherwise be incurred in the medical assistance program. The commissioner shall purchase
261.21 the most cost-effective coverage available for eligible individuals.

267.23 cost sharing, including co-payments and deductibles required under section 256B.0631.
267.24 The commissioner shall not pay for that portion of a premium that is attributable to other
267.25 family members or dependents or is paid by the individual's employer.

267.26 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
267.27 satisfy the following requirements: meet all eligibility requirements for and enroll in Part
267.28 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

267.29 (1) the applicant must provide a physician's, advanced practice registered nurse's, or
267.30 physician assistant's statement verifying that the applicant is infected with HIV and is, or
267.31 within three months is likely to become, too ill to work in the applicant's current employment
267.32 because of HIV-related disease;

268.1 (2) the applicant's monthly gross family income must not exceed 300 percent of the
268.2 federal poverty guidelines, after deducting medical expenses and insurance premiums;

268.3 (3) the applicant must not own assets with a combined value of more than $25,000; and

268.4 (4) if applying for payment of group plan premiums, the applicant must be covered by
268.5 an employer's or former employer's group insurance plan.

268.6 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
268.7 premiums under subdivision 2, clause (5), this section must be designed to ensure that the
268.8 state cost of paying an individual plan premium does not exceed the estimated state cost
268.9 that would otherwise be incurred in the medical assistance program. The commissioner
268.10 shall purchase the most cost-effective coverage available for eligible individuals.

ARTICLE 5:

174.18 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 19a, is amended to
174.19 read:

174.20 Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care
174.21 assistance services in a recipient's home. Effective January 1, 2010 2020, to qualify for
174.22 personal care assistance services, a recipient must require assistance and be determined
174.23 dependent in one critical activity of daily living as defined in section 256B.0659, subdivision
174.24 1, paragraph (b) (e), or in a Level I behavior as defined in section 256B.0659, subdivision
174.25 1, paragraph (c), or have a behavior that shows increased vulnerability due to cognitive
174.26 deficits or socially inappropriate behavior that requires assistance at least four times per
174.27 week. Recipients or responsible parties must be able to identify the recipient's needs, direct
174.28 and evaluate task accomplishment, and provide for health and safety. Approved hours may
174.29 be used outside the home when normal life activities take them outside the home. To use
174.30 personal care assistance services at school, the recipient or responsible party must provide
174.31 written authorization in the care plan identifying the chosen provider and the daily amount
174.32 of services to be used at school. Total hours for services, whether actually performed inside
174.33 or outside the recipient's home, cannot exceed that which is otherwise allowed for personal

174.34 care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654.
175.1 Medical assistance does not cover personal care assistance services for residents of a hospital,
175.2 nursing facility, intermediate care facility, health care facility licensed by the commissioner
175.3 of health, or unless a resident who is otherwise eligible is on leave from the facility and the
175.4 facility either pays for the personal care assistance services or forgoes the facility per diem
175.5 for the leave days that personal care assistance services are used. All personal care assistance
175.6 services must be provided according to sections 256B.0651 to 256B.0654. Personal care
175.7 assistance services may not be reimbursed if the personal care assistant is the spouse or paid
175.8 guardian of the recipient or the parent of a recipient under age 18, or the responsible party
175.9 or the family foster care provider of a recipient who cannot direct the recipient's own care
175.10 unless, in the case of a foster care provider, a county or state case manager visits the recipient
175.11 as needed, but not less than every six months, to monitor the health and safety of the recipient
175.12 and to ensure the goals of the care plan are met. Notwithstanding the provisions of section
175.13 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party
175.14 and not the personal care provider organization, may be reimbursed to provide personal
175.15 care assistance services to the recipient if the guardian or conservator meets all criteria for
175.16 a personal care assistant according to section 256B.0659, and shall not be considered to
175.17 have a service provider interest for purposes of participation on the screening team under
175.18 section 256B.092, subdivision 7.

175.19 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
175.20 whichever is later. The commissioner shall implement the modified eligibility criteria as
175.21 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
175.22 approval is obtained.

175.23 Sec. 13. Minnesota Statutes 2018, section 256B.0652, subdivision 6, is amended to read:

175.24 Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All
175.25 personal care assistance services, supervision by a qualified professional, and additional
175.26 services beyond the limits established in subdivision 11, must be authorized by the
175.27 commissioner or the commissioner's designee before services begin except for the
175.28 assessments established in subdivision 11 and section 256B.0911. The authorization for
175.29 personal care assistance and qualified professional services under section 256B.0659 must
175.30 be completed within 30 days after receiving a complete request.

175.31 (b) The amount of personal care assistance services authorized must be based on the
175.32 recipient's home care rating. The home care rating shall be determined by the commissioner
175.33 or the commissioner's designee based on information submitted to the commissioner
176.1 identifying the following for recipients with dependencies in two or more activities of daily
176.2 living:

176.3 (1) total number of dependencies of activities of daily living as defined in section
176.4 256B.0659;

176.5 (2) presence of complex health-related needs as defined in section 256B.0659; and

261.22 Sec. 30. Minnesota Statutes 2018, section 256B.0658, is amended to read:
261.23 256B.0658 HOUSING ACCESS GRANTS.

261.24 The commissioner of human services shall award through a competitive process contracts
261.25 for grants to public and private agencies to support and assist individuals ~~eligible for publicly~~
261.26 ~~funded home and community-based services, including state plan home care~~ with a disability
261.27 as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may
261.28 be awarded to agencies that may include, but are not limited to, the following supports:
261.29 assessment to ensure suitability of housing, accompanying an individual to look at housing,
261.30 filling out applications and rental agreements, meeting with landlords, helping with Section

176.6 (3) presence of Level I behavior as defined in section 256B.0659.

176.7 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
176.8 total time for personal care assistance services for each home care rating is based on the
176.9 median paid units per day for each home care rating from fiscal year 2007 data for the
176.10 personal care assistance program. Each home care rating has a base level of hours assigned.
176.11 Additional time is added through the assessment and identification of the following:

176.12 (1) 30 additional minutes per day for a dependency in each critical activity of daily living
176.13 as defined in section 256B.0659;

176.14 (2) 30 additional minutes per day for each complex health-related function as defined
176.15 in section 256B.0659; and

176.16 (3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659,
176.17 subdivision 4, paragraph (d).

176.18 (d) Effective July 1, 2011, the home care rating for recipients who have a dependency
176.19 in one activity of daily living or Level I behavior shall equal no more than two units per
176.20 day. Effective January 1, 2020, the home care rating for recipients who have a dependency
176.21 in one critical activity of daily living or one Level I behavior or that require assistance with
176.22 a behavior that shows increased vulnerability due to cognitive deficits or socially
176.23 inappropriate behavior at least four times per week shall equal no more than two units per
176.24 day. Recipients with this home care rating are not subject to the methodology in paragraph
176.25 (c) and are not eligible for more than two units per day.

176.26 (e) A limit of 96 units of qualified professional supervision may be authorized for each
176.27 recipient receiving personal care assistance services. A request to the commissioner to
176.28 exceed this total in a calendar year must be requested by the personal care provider agency
176.29 on a form approved by the commissioner.

176.30 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
176.31 whichever is later. The commissioner shall implement the modified eligibility criteria as
176.32 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
176.33 approval is obtained.

177.1 Sec. 14. Minnesota Statutes 2018, section 256B.0658, is amended to read:
177.2 256B.0658 HOUSING ACCESS GRANTS.

177.3 The commissioner of human services shall award through a competitive process contracts
177.4 for grants to public and private agencies to support and assist individuals ~~eligible for publicly~~
177.5 ~~funded home and community-based services, including state plan home care~~ with a disability
177.6 as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may
177.7 be awarded to agencies that may include, but are not limited to, the following supports:
177.8 assessment to ensure suitability of housing, accompanying an individual to look at housing,
177.9 filling out applications and rental agreements, meeting with landlords, helping with Section

261.31 8 or other program applications, helping to develop a budget, obtaining furniture and
261.32 household goods, if necessary, and assisting with any problems that may arise with housing.

177.10 8 or other program applications, helping to develop a budget, obtaining furniture and
177.11 household goods, if necessary, and assisting with any problems that may arise with housing.

ARTICLE 1:

39.1 Sec. 38. Minnesota Statutes 2018, section 256B.0659, subdivision 3, is amended to read:

39.2 Subd. 3. ~~**Noncovered**~~ **Personal care assistance services not covered.** (a) Personal care
39.3 assistance services are not eligible for medical assistance payment under this section when
39.4 provided:

39.5 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian,
39.6 licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or
39.7 responsible party;

39.8 (2) in order to meet staffing or license requirements in a residential or child care setting;

39.9 (3) solely as a child care or babysitting service; ~~or~~

39.10 (4) without authorization by the commissioner or the commissioner's designee~~.~~; or

39.11 (5) on dates not within the frequency requirements of subdivision 14, paragraph (c), and
39.12 subdivision 19, paragraph (a).

39.13 (b) The following personal care services are not eligible for medical assistance payment
39.14 under this section when provided in residential settings:

39.15 (1) when the provider of home care services who is not related by blood, marriage, or
39.16 adoption owns or otherwise controls the living arrangement, including licensed or unlicensed
39.17 services; or

39.18 (2) when personal care assistance services are the responsibility of a residential or
39.19 program license holder under the terms of a service agreement and administrative rules.

39.20 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for
39.21 medical assistance reimbursement for personal care assistance services under this section
39.22 include:

39.23 (1) sterile procedures;

39.24 (2) injections of fluids and medications into veins, muscles, or skin;

39.25 (3) home maintenance or chore services;

39.26 (4) homemaker services not an integral part of assessed personal care assistance services
39.27 needed by a recipient;

39.28 (5) application of restraints or implementation of procedures under section 245.825;

39.29 (6) instrumental activities of daily living for children under the age of 18, except when
39.30 immediate attention is needed for health or hygiene reasons integral to the personal care
39.31 services and the need is listed in the service plan by the assessor; and

40.1 (7) assessments for personal care assistance services by personal care assistance provider
40.2 agencies or by independently enrolled registered nurses.

ARTICLE 5:

177.12 Sec. 15. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

177.13 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a
177.14 recipient's need for personal care assistance services conducted in person. Assessments for
177.15 personal care assistance services shall be conducted by the county public health nurse or a
177.16 certified public health nurse under contract with the county except when a long-term care
177.17 consultation assessment is being conducted for the purposes of determining a person's
177.18 eligibility for home and community-based waiver services including personal care assistance
177.19 services according to section 256B.0911. During the transition to MnCHOICES, a certified
177.20 assessor may complete the assessment defined in this subdivision. An in-person assessment
177.21 must include: documentation of health status, determination of need, evaluation of service
177.22 effectiveness, identification of appropriate services, service plan development or modification,
177.23 coordination of services, referrals and follow-up to appropriate payers and community
177.24 resources, completion of required reports, recommendation of service authorization, and
177.25 consumer education. Once the need for personal care assistance services is determined under
177.26 this section, the county public health nurse or certified public health nurse under contract
177.27 with the county is responsible for communicating this recommendation to the commissioner
177.28 and the recipient. An in-person assessment must occur at least annually or when there is a
177.29 significant change in the recipient's condition or when there is a change in the need for
177.30 personal care assistance services. A service update may substitute for the annual face-to-face
177.31 assessment when there is not a significant change in recipient condition or a change in the
177.32 need for personal care assistance service. A service update may be completed by telephone,
177.33 used when there is no need for an increase in personal care assistance services, and used
177.34 for two consecutive assessments if followed by a face-to-face assessment. A service update
178.1 must be completed on a form approved by the commissioner. A service update or review
178.2 for temporary increase includes a review of initial baseline data, evaluation of service
178.3 effectiveness, redetermination of service need, modification of service plan and appropriate
178.4 referrals, update of initial forms, obtaining service authorization, and on going consumer
178.5 education. Assessments or reassessments must be completed on forms provided by the
178.6 commissioner within 30 days of a request for home care services by a recipient or responsible
178.7 party.

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

262.1 Sec. 31. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

178.10 Sec. 16. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

House Language H2414-2

262.2 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
262.3 meet the following requirements:

262.4 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
262.5 age with these additional requirements:

262.6 (i) supervision by a qualified professional every 60 days; and

262.7 (ii) employment by only one personal care assistance provider agency responsible for
262.8 compliance with current labor laws;

262.9 (2) be employed by a personal care assistance provider agency;

262.10 (3) enroll with the department as a personal care assistant after clearing a background
262.11 study. Except as provided in subdivision 11a, before a personal care assistant provides
262.12 services, the personal care assistance provider agency must initiate a background study on
262.13 the personal care assistant under chapter 245C, and the personal care assistance provider
262.14 agency must have received a notice from the commissioner that the personal care assistant
262.15 is:

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

262.17 (ii) is disqualified, but the personal care assistant has received a set aside of the
262.18 disqualification under section 245C.22;

262.19 (4) be able to effectively communicate with the recipient and personal care assistance
262.20 provider agency;

262.21 (5) be able to provide covered personal care assistance services according to the recipient's
262.22 personal care assistance care plan, respond appropriately to recipient needs, and report
262.23 changes in the recipient's condition to the supervising qualified professional or physician;

262.24 (6) not be a consumer of personal care assistance services;

262.25 (7) maintain daily written records including, but not limited to, time sheets under
262.26 subdivision 12;

262.27 (8) effective January 1, 2010, complete standardized training as determined by the
262.28 commissioner before completing enrollment. The training must be available in languages
262.29 other than English and to those who need accommodations due to disabilities. Personal care
262.30 assistant training must include successful completion of the following training components:
262.31 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
262.32 roles and responsibilities of personal care assistants including information about assistance
263.1 with lifting and transfers for recipients, emergency preparedness, orientation to positive
263.2 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
263.3 training components, the personal care assistant must demonstrate the competency to provide
263.4 assistance to recipients;

263.5 (9) complete training and orientation on the needs of the recipient; and

Senate Language UEH2414-1

178.11 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
178.12 meet the following requirements:

178.13 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
178.14 age with these additional requirements:

178.15 (i) supervision by a qualified professional every 60 days; and

178.16 (ii) employment by only one personal care assistance provider agency responsible for
178.17 compliance with current labor laws;

178.18 (2) be employed by a personal care assistance provider agency;

178.19 (3) enroll with the department as a personal care assistant after clearing a background
178.20 study. Except as provided in subdivision 11a, before a personal care assistant provides
178.21 services, the personal care assistance provider agency must initiate a background study on
178.22 the personal care assistant under chapter 245C, and the personal care assistance provider
178.23 agency must have received a notice from the commissioner that the personal care assistant
178.24 is:

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

178.26 (ii) is disqualified, but the personal care assistant has received a set aside of the
178.27 disqualification under section 245C.22;

178.28 (4) be able to effectively communicate with the recipient and personal care assistance
178.29 provider agency;

178.30 (5) be able to provide covered personal care assistance services according to the recipient's
178.31 personal care assistance care plan, respond appropriately to recipient needs, and report
178.32 changes in the recipient's condition to the supervising qualified professional or physician;

179.1 (6) not be a consumer of personal care assistance services;

179.2 (7) maintain daily written records including, but not limited to, time sheets under
179.3 subdivision 12;

179.4 (8) effective January 1, 2010, complete standardized training as determined by the
179.5 commissioner before completing enrollment. The training must be available in languages
179.6 other than English and to those who need accommodations due to disabilities. Personal care
179.7 assistant training must include successful completion of the following training components:
179.8 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
179.9 roles and responsibilities of personal care assistants including information about assistance
179.10 with lifting and transfers for recipients, emergency preparedness, orientation to positive
179.11 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
179.12 training components, the personal care assistant must demonstrate the competency to provide
179.13 assistance to recipients;

179.14 (9) complete training and orientation on the needs of the recipient; and

House Language H2414-2

263.6 (10) be limited to providing and being paid for up to 275 hours per month of personal
263.7 care assistance services regardless of the number of recipients being served or the number
263.8 of personal care assistance provider agencies enrolled with. The number of hours worked
263.9 per day shall not be disallowed by the department unless in violation of the law.

263.10 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
263.11 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

263.12 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
263.13 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
263.14 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
263.15 a residential setting.

263.16 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
263.17 17a if the personal care assistant providing the services:

263.18 (1) provides services, according to the care plan in subdivision 7, to a recipient who
263.19 qualifies for 12 or more hours per day of personal care assistance services; and

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

263.24 **EFFECTIVE DATE.** This section is effective July 1, 2019.

Senate Language UEH2414-1

179.15 (10) be limited to providing and being paid for up to 275 hours per month of personal
179.16 care assistance services regardless of the number of recipients being served or the number
179.17 of personal care assistance provider agencies enrolled with. The number of hours worked
179.18 per day shall not be disallowed by the department unless in violation of the law.

179.19 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
179.20 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

179.21 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
179.22 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
179.23 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
179.24 a residential setting.

179.25 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
179.26 17a if the personal care assistant providing the services:

179.27 (1) provides services, according to the care plan in subdivision 7, to a recipient who
179.28 qualifies for ten or more hours per day of personal care assistance services; and

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

179.33 **EFFECTIVE DATE.** This section is effective July 1, 2019.

ARTICLE 1:

40.26 Sec. 40. Minnesota Statutes 2018, section 256B.0659, subdivision 13, is amended to read:

40.27 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must
40.28 work for a personal care assistance provider agency ~~and~~, meet the definition of qualified
40.29 professional under section 256B.0625, subdivision 19c, and enroll with the department as
40.30 a qualified professional after clearing a background study. Before a qualified professional
41.1 provides services, the personal care assistance provider agency must initiate a background
41.2 study on the qualified professional under chapter 245C, and the personal care assistance
41.3 provider agency must have received a notice from the commissioner that the qualified
41.4 professional:

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

41.6 (2) is disqualified, but the qualified professional has received a set aside of the
41.7 disqualification under section 245C.22.

41.8 (b) The qualified professional shall perform the duties of training, supervision, and
41.9 evaluation of the personal care assistance staff and evaluation of the effectiveness of personal
41.10 care assistance services. The qualified professional shall:

41.11 (1) develop and monitor with the recipient a personal care assistance care plan based on
41.12 the service plan and individualized needs of the recipient;

41.13 (2) develop and monitor with the recipient a monthly plan for the use of personal care
41.14 assistance services;

41.15 (3) review documentation of personal care assistance services provided;

41.16 (4) provide training and ensure competency for the personal care assistant in the individual
41.17 needs of the recipient; and

41.18 (5) document all training, communication, evaluations, and needed actions to improve
41.19 performance of the personal care assistants.

41.20 (c) Effective July 1, 2011, the qualified professional shall complete the provider training
41.21 with basic information about the personal care assistance program approved by the
41.22 commissioner. Newly hired qualified professionals must complete the training within six
41.23 months of the date hired by a personal care assistance provider agency. Qualified
41.24 professionals who have completed the required training as a worker from a personal care
41.25 assistance provider agency do not need to repeat the required training if they are hired by
41.26 another agency, if they have completed the training within the last three years. The required
41.27 training must be available with meaningful access according to title VI of the Civil Rights
41.28 Act and federal regulations adopted under that law or any guidance from the United States
41.29 Health and Human Services Department. The required training must be available online or
41.30 by electronic remote connection. The required training must provide for competency testing
41.31 to demonstrate an understanding of the content without attending in-person training. A
41.32 qualified professional is allowed to be employed and is not subject to the training requirement
41.33 until the training is offered online or through remote electronic connection. A qualified
42.1 professional employed by a personal care assistance provider agency certified for
42.2 participation in Medicare as a home health agency is exempt from the training required in
42.3 this subdivision. When available, the qualified professional working for a Medicare-certified
42.4 home health agency must successfully complete the competency test. The commissioner
42.5 shall ensure there is a mechanism in place to verify the identity of persons completing the
42.6 competency testing electronically.

42.7 Sec. 41. Minnesota Statutes 2018, section 256B.0659, subdivision 14, is amended to read:

42.8 Subd. 14. **Qualified professional; duties.** (a) Effective January 1, ~~2010~~ 2020, all personal
42.9 care assistants must be supervised by a qualified professional who is enrolled as an individual
42.10 provider with the commissioner under section 256B.04, subdivision 21, paragraph (c).

42.11 (b) Through direct training, observation, return demonstrations, and consultation with
42.12 the staff and the recipient, the qualified professional must ensure and document that the
42.13 personal care assistant is:

42.14 (1) capable of providing the required personal care assistance services;

42.15 (2) knowledgeable about the plan of personal care assistance services before services
42.16 are performed; and

42.17 (3) able to identify conditions that should be immediately brought to the attention of the
42.18 qualified professional.

42.19 (c) The qualified professional shall evaluate the personal care assistant within the first
42.20 14 days of starting to provide regularly scheduled services for a recipient, or sooner as
42.21 determined by the qualified professional, except for the personal care assistance choice
42.22 option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified
42.23 professional shall evaluate the personal care assistance services for a recipient through direct
42.24 observation of a personal care assistant's work. The qualified professional may conduct
42.25 additional training and evaluation visits, based upon the needs of the recipient and the
42.26 personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal
42.27 care assistance services provided to a recipient do not require direct observation of each
42.28 personal care assistant's work and shall occur:

42.29 (1) at least every 90 days thereafter for the first year of a recipient's services;

42.30 (2) every 120 days after the first year of a recipient's service or whenever needed for
42.31 response to a recipient's request for increased supervision of the personal care assistance
42.32 staff; and

43.1 (3) after the first 180 days of a recipient's service, supervisory visits may alternate
43.2 between unscheduled phone or Internet technology and in-person visits, unless the in-person
43.3 visits are needed according to the care plan.

43.4 (d) Communication with the recipient is a part of the evaluation process of the personal
43.5 care assistance staff.

43.6 (e) At each supervisory visit, the qualified professional shall evaluate personal care
43.7 assistance services including the following information:

43.8 (1) satisfaction level of the recipient with personal care assistance services;

43.9 (2) review of the month-to-month plan for use of personal care assistance services;

43.10 (3) review of documentation of personal care assistance services provided;

43.11 (4) whether the personal care assistance services are meeting the goals of the service as
43.12 stated in the personal care assistance care plan and service plan;

43.13 (5) a written record of the results of the evaluation and actions taken to correct any
43.14 deficiencies in the work of a personal care assistant; and

43.15 (6) revision of the personal care assistance care plan as necessary in consultation with
43.16 the recipient or responsible party, to meet the needs of the recipient.

43.17 (f) The qualified professional shall complete the required documentation in the agency
43.18 recipient and employee files and the recipient's home, including the following documentation:

43.19 (1) the personal care assistance care plan based on the service plan and individualized
43.20 needs of the recipient;

43.21 (2) a month-to-month plan for use of personal care assistance services;

43.22 (3) changes in need of the recipient requiring a change to the level of service and the
43.23 personal care assistance care plan;

43.24 (4) evaluation results of supervision visits and identified issues with personal care
43.25 assistance staff with actions taken;

43.26 (5) all communication with the recipient and personal care assistance staff; and

43.27 (6) hands-on training or individualized training for the care of the recipient.

43.28 (g) The documentation in paragraph (f) must be done on agency templates.

43.29 (h) The services that are not eligible for payment as qualified professional services
43.30 include:

44.1 (1) direct professional nursing tasks that could be assessed and authorized as skilled
44.2 nursing tasks;

44.3 (2) agency administrative activities;

44.4 (3) training other than the individualized training required to provide care for a recipient;
44.5 and

44.6 (4) any other activity that is not described in this section.

44.7 (i) The qualified professional shall notify the commissioner on a form prescribed by the
44.8 commissioner, within 30 days of when a qualified professional is no longer employed by
44.9 or otherwise affiliated with the personal care assistance agency for whom the qualified
44.10 professional previously provided qualified professional services.

ARTICLE 5:

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263.25 Sec. 32. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision
263.26 to read:

263.27 Subd. 17a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for
263.28 personal care assistance services shall be paid for services provided to persons who qualify
263.29 for 12 or more hours of personal care assistance services per day when provided by a personal
263.30 care assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced
263.31 rate for personal care assistance services includes, and is not in addition to, any rate
263.32 adjustments implemented by the commissioner on July 1, 2019, to comply with the terms
264.1 of a collective bargaining agreement between the state of Minnesota and an exclusive

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180.1 Sec. 17. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision
180.2 to read:

180.3 Subd. 17a. **Enhanced rate.** An enhanced rate of 110 percent of the rate paid for personal
180.4 care assistance services shall be paid for services provided to persons who qualify for ten
180.5 or more hours of personal care assistance service per day when provided by a personal care
180.6 assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate
180.7 for personal care assistance services includes, and is not in addition to, any rate adjustments
180.8 implemented by the commissioner to comply with the terms of a collective bargaining
180.9 agreement between the state of Minnesota and an exclusive representative of individual

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264.2 representative of individual providers under section 179A.54, that provides for wage increases
264.3 for individual providers who serve participants assessed to need 12 or more hours of personal
264.4 care assistance services per day.

264.5 **EFFECTIVE DATE.** This section is effective July 1, 2019.

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180.10 providers under section 179A.54 for increased financial incentives for providing services
180.11 to people with complex needs.

180.12 **EFFECTIVE DATE.** This section is effective July 1, 2019.

ARTICLE 1:

44.11 Sec. 42. Minnesota Statutes 2018, section 256B.0659, subdivision 19, is amended to read:

44.12 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under
44.13 personal care assistance choice, the recipient or responsible party shall:

44.14 (1) recruit, hire, schedule, and terminate personal care assistants according to the terms
44.15 of the written agreement required under subdivision 20, paragraph (a);

44.16 (2) develop a personal care assistance care plan based on the assessed needs and
44.17 addressing the health and safety of the recipient with the assistance of a qualified professional
44.18 as needed;

44.19 (3) orient and train the personal care assistant with assistance as needed from the qualified
44.20 professional;

44.21 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with the
44.22 qualified professional, who is required to visit the recipient at least every 180 days;

44.23 (5) monitor and verify in writing and report to the personal care assistance choice agency
44.24 the number of hours worked by the personal care assistant and the qualified professional;

44.25 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
44.26 and service authorization; and

44.27 (7) use the same personal care assistance choice provider agency if shared personal
44.28 assistance care is being used.

44.29 (b) The personal care assistance choice provider agency shall:

44.30 (1) meet all personal care assistance provider agency standards;

45.1 (2) enter into a written agreement with the recipient, responsible party, and personal
45.2 care assistants;

45.3 (3) not be related as a parent, child, sibling, or spouse to the recipient or the personal
45.4 care assistant; and

45.5 (4) ensure arm's-length transactions without undue influence or coercion with the recipient
45.6 and personal care assistant.

45.7 (c) The duties of the personal care assistance choice provider agency are to:

45.8 (1) be the employer of the personal care assistant and the qualified professional for
45.9 employment law and related regulations including, but not limited to, purchasing and
45.10 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
45.11 and liability insurance, and submit any or all necessary documentation including, but not
45.12 limited to, workers' compensation ~~and~~, unemployment insurance, and labor market data
45.13 required under section 256B.4912, subdivision 1a;

45.14 (2) bill the medical assistance program for personal care assistance services and qualified
45.15 professional services;

45.16 (3) request and complete background studies that comply with the requirements for
45.17 personal care assistants and qualified professionals;

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

45.20 (5) withhold and pay all applicable federal and state taxes;

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

45.23 (7) make the arrangements and pay taxes and other benefits, if any, and comply with
45.24 any legal requirements for a Minnesota employer;

45.25 (8) enroll in the medical assistance program as a personal care assistance choice agency;
45.26 and

45.27 (9) enter into a written agreement as specified in subdivision 20 before services are
45.28 provided.

264.6 Sec. 33. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

264.7 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
264.8 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
264.9 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
264.10 a format determined by the commissioner, information and documentation that includes,
264.11 but is not limited to, the following:

264.12 (1) the personal care assistance provider agency's current contact information including
264.13 address, telephone number, and e-mail address;

264.14 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
264.15 revenue in the previous calendar year is up to and including $300,000, the provider agency
264.16 must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is
264.17 over $300,000, the provider agency must purchase a surety bond of $100,000. The surety
264.18 bond must be in a form approved by the commissioner, must be renewed annually, and must
264.19 allow for recovery of costs and fees in pursuing a claim on the bond;

264.20 (3) proof of fidelity bond coverage in the amount of $20,000;

180.13 Sec. 18. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

180.14 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
180.15 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
180.16 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
180.17 a format determined by the commissioner, information and documentation that includes,
180.18 but is not limited to, the following:

180.19 (1) the personal care assistance provider agency's current contact information including
180.20 address, telephone number, and e-mail address;

180.21 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
180.22 revenue in the previous calendar year is up to and including $300,000, the provider agency
180.23 must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is
180.24 over $300,000, the provider agency must purchase a surety bond of $100,000. The surety
180.25 bond must be in a form approved by the commissioner, must be renewed annually, and must
180.26 allow for recovery of costs and fees in pursuing a claim on the bond;

180.27 (3) proof of fidelity bond coverage in the amount of $20,000;

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264.21 (4) proof of workers' compensation insurance coverage;	180.28 (4) proof of workers' compensation insurance coverage;
264.22 (5) proof of liability insurance;	180.29 (5) proof of liability insurance;
264.23 (6) a description of the personal care assistance provider agency's organization identifying 264.24 the names of all owners, managing employees, staff, board of directors, and the affiliations 264.25 of the directors, owners, or staff to other service providers;	180.30 (6) a description of the personal care assistance provider agency's organization identifying 180.31 the names of all owners, managing employees, staff, board of directors, and the affiliations 180.32 of the directors, owners, or staff to other service providers;
264.26 (7) a copy of the personal care assistance provider agency's written policies and 264.27 procedures including: hiring of employees; training requirements; service delivery; and 264.28 employee and consumer safety including process for notification and resolution of consumer 264.29 grievances, identification and prevention of communicable diseases, and employee 264.30 misconduct;	181.1 (7) a copy of the personal care assistance provider agency's written policies and 181.2 procedures including: hiring of employees; training requirements; service delivery; and 181.3 employee and consumer safety including process for notification and resolution of consumer 181.4 grievances, identification and prevention of communicable diseases, and employee 181.5 misconduct;
264.31 (8) copies of all other forms the personal care assistance provider agency uses in the 264.32 course of daily business including, but not limited to:	181.6 (8) copies of all other forms the personal care assistance provider agency uses in the 181.7 course of daily business including, but not limited to:
265.1 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet 265.2 varies from the standard time sheet for personal care assistance services approved by the 265.3 commissioner, and a letter requesting approval of the personal care assistance provider 265.4 agency's nonstandard time sheet;	181.8 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet 181.9 varies from the standard time sheet for personal care assistance services approved by the 181.10 commissioner, and a letter requesting approval of the personal care assistance provider 181.11 agency's nonstandard time sheet;
265.5 (ii) the personal care assistance provider agency's template for the personal care assistance 265.6 care plan; and	181.12 (ii) the personal care assistance provider agency's template for the personal care assistance 181.13 care plan; and
265.7 (iii) the personal care assistance provider agency's template for the written agreement 265.8 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;	181.14 (iii) the personal care assistance provider agency's template for the written agreement 181.15 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;
265.9 (9) a list of all training and classes that the personal care assistance provider agency 265.10 requires of its staff providing personal care assistance services;	181.16 (9) a list of all training and classes that the personal care assistance provider agency 181.17 requires of its staff providing personal care assistance services;
265.11 (10) documentation that the personal care assistance provider agency and staff have 265.12 successfully completed all the training required by this section;	181.18 (10) documentation that the personal care assistance provider agency and staff have 181.19 successfully completed all the training required by this section, including the requirements 181.20 under subdivision 11, paragraph (d), if enhanced personal care assistance services are 181.21 provided and submitted for an enhanced rate under subdivision 17a;
265.13 (11) documentation of the agency's marketing practices;	181.22 (11) documentation of the agency's marketing practices;
265.14 (12) disclosure of ownership, leasing, or management of all residential properties that 265.15 is used or could be used for providing home care services;	181.23 (12) disclosure of ownership, leasing, or management of all residential properties that 181.24 is used or could be used for providing home care services;
265.16 (13) documentation that the agency will use the following percentages of revenue 265.17 generated from the medical assistance rate paid for personal care assistance services for 265.18 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal 265.19 care assistance choice option and 72.5 percent of revenue from other personal care assistance 265.20 providers, except for other personal care assistance providers, all of the revenue generated 265.21 by a medical assistance rate increase due to a collective bargaining agreement under section 265.22 179A.54 must be used for employee personal care assistant wages and benefits. The revenue	181.25 (13) documentation that the agency will use the following percentages of revenue 181.26 generated from the medical assistance rate paid for personal care assistance services for 181.27 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal 181.28 care assistance choice option and 72.5 percent of revenue from other personal care assistance 181.29 providers. The revenue generated by the qualified professional and the reasonable costs 181.30 associated with the qualified professional shall not be used in making this calculation; and

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265.23 generated by the qualified professional and the reasonable costs associated with the qualified
265.24 professional shall not be used in making this calculation; and

265.25 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
265.26 free exercise of their right to choose service providers by requiring personal care assistants
265.27 to sign an agreement not to work with any particular personal care assistance recipient or
265.28 for another personal care assistance provider agency after leaving the agency and that the
265.29 agency is not taking action on any such agreements or requirements regardless of the date
265.30 signed.

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

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

266.25 Sec. 34. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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181.31 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
181.32 free exercise of their right to choose service providers by requiring personal care assistants
181.33 to sign an agreement not to work with any particular personal care assistance recipient or
182.1 for another personal care assistance provider agency after leaving the agency and that the
182.2 agency is not taking action on any such agreements or requirements regardless of the date
182.3 signed.

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

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

182.31 **EFFECTIVE DATE.** This section is effective July 1, 2019.

182.32 Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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266.28 266.29	(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;	183.1 183.2	(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;
266.30	(2) comply with general medical assistance coverage requirements;	183.3	(2) comply with general medical assistance coverage requirements;
266.31 266.32	(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;	183.4 183.5	(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;
266.33	(4) comply with background study requirements;	183.6	(4) comply with background study requirements;
267.1 267.2	(5) verify and keep records of hours worked by the personal care assistant and qualified professional;	183.7 183.8	(5) verify and keep records of hours worked by the personal care assistant and qualified professional;
267.3 267.4	(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;	183.9 183.10	(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;
267.5 267.6	(7) pay the personal care assistant and qualified professional based on actual hours of services provided;	183.11 183.12	(7) pay the personal care assistant and qualified professional based on actual hours of services provided;
267.7	(8) withhold and pay all applicable federal and state taxes;	183.13	(8) withhold and pay all applicable federal and state taxes;
267.8 267.9 267.10 267.11 267.12	(9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;	183.14 183.15 183.16 183.17 183.18	(9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;
267.13 267.14	(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;	183.19 183.20	(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;
267.15	(11) enter into a written agreement under subdivision 20 before services are provided;	183.21	(11) enter into a written agreement under subdivision 20 before services are provided;
267.16 267.17	(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;	183.22 183.23	(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;
267.18 267.19	(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~	183.24 183.25	(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~
267.20 267.21	(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner~~.~~; and	183.26 183.27	(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner~~.~~; and
267.22 267.23 267.24	(15) document that the additional revenue the agency receives for the enhanced rate is passed on, in wages and benefits, to the personal care assistant who provided services to a recipient who is eligible for the enhanced rate.	183.28 183.29 183.30	(15) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d).
267.25	**EFFECTIVE DATE.** This section is effective July 1, 2019.	183.31	**EFFECTIVE DATE.** This section is effective July 1, 2019.
			ARTICLE 1:
		49.1	Sec. 44. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

49.6 (2) comply with general medical assistance coverage requirements;

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

49.9 (4) comply with background study requirements;

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

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

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

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

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

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

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

49.25 (12) report suspected neglect and abuse to the common entry point according to section
49.26 256B.0651;

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

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

50.1 (15) comply with the labor market reporting requirements described in section 256B.4912,
50.2 subdivision 1a.

ARTICLE 5:

267.26 Sec. 35. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

184.1 Sec. 20. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

House Language H2414-2	Senate Language UEH2414-1
267.27 Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:	184.2 Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:
267.30 (1) employee files, including:	184.5 (1) employee files, including:
267.31 (i) applications for employment;	184.6 (i) applications for employment;
268.1 (ii) background study requests and results;	184.7 (ii) background study requests and results;
268.2 (iii) orientation records about the agency policies;	184.8 (iii) orientation records about the agency policies;
268.3 (iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), if personal care assistance services eligible for the enhanced rate are provided and submitted for reimbursement under this section;	184.9 (iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), for any services billed at the enhanced rate under subdivision 17a;
268.7 (v) supervisory visits;	184.12 (v) supervisory visits;
268.8 (vi) evaluations of employment; and	184.13 (vi) evaluations of employment; and
268.9 (vii) signature on fraud statement;	184.14 (vii) signature on fraud statement;
268.10 (2) recipient files, including:	184.15 (2) recipient files, including:
268.11 (i) demographics;	184.16 (i) demographics;
268.12 (ii) emergency contact information and emergency backup plan;	184.17 (ii) emergency contact information and emergency backup plan;
268.13 (iii) personal care assistance service plan;	184.18 (iii) personal care assistance service plan;
268.14 (iv) personal care assistance care plan;	184.19 (iv) personal care assistance care plan;
268.15 (v) month-to-month service use plan;	184.20 (v) month-to-month service use plan;
268.16 (vi) all communication records;	184.21 (vi) all communication records;
268.17 (vii) start of service information, including the written agreement with recipient; and	184.22 (vii) start of service information, including the written agreement with recipient; and
268.18 (viii) date the home care bill of rights was given to the recipient;	184.23 (viii) date the home care bill of rights was given to the recipient;
268.19 (3) agency policy manual, including:	184.24 (3) agency policy manual, including:
268.20 (i) policies for employment and termination;	184.25 (i) policies for employment and termination;
268.21 (ii) grievance policies with resolution of consumer grievances;	184.26 (ii) grievance policies with resolution of consumer grievances;
268.22 (iii) staff and consumer safety;	184.27 (iii) staff and consumer safety;
268.23 (iv) staff misconduct; and	184.28 (iv) staff misconduct; and
268.24 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;	185.1 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

House Language H2414-2

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

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

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

269.3 **EFFECTIVE DATE.** This section is effective July 1, 2019.

269.4 Sec. 36. [256B.0715] DIRECT CARE WORKFORCE REPORT.

269.5 The commissioner of human services shall annually assess the direct care workforce
269.6 and publish findings in a direct care workforce report each August beginning August 1,
269.7 2020. This report shall consider the number of workers employed, the number of regular
269.8 hours worked, the number of overtime hours worked, the regular wages and benefits paid,
269.9 the overtime wages paid, retention rates, and job vacancies across providers of home and
269.10 community-based services disability waiver services, state plan home care services, state
269.11 plan personal care assistance services, and community first services and supports.

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

Senate Language UEH2414-1

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

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

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

185.9 **EFFECTIVE DATE.** This section is effective July 1, 2019.

185.10 Sec. 21. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

185.23 (6) determination of home and community-based waiver and other service eligibility as
185.24 required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level
185.25 of care determination for individuals who need an institutional level of care as determined
185.26 under subdivision 4e, based on assessment and community support plan development,

185.27 appropriate referrals to obtain necessary diagnostic information, and including an eligibility
185.28 determination for consumer-directed community supports;

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

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

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

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

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

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

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

186.16 (iii) section 256B.85;

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

186.21 (3) determination ~~of institutional level of care, home and community-based service~~
186.22 ~~waiver, and other service~~ of eligibility ~~as required under section 256B.092, determination~~
186.23 ~~of eligibility for family support grants under section 252.32,~~ for semi-independent living
186.24 services under section 252.275~~, and day training and habilitation services under section~~
186.25 ~~256B.092~~; and

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

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

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

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

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

187.15 Sec. 22. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

187.16 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
187.17 planning, or other assistance intended to support community-based living, including persons
187.18 who need assessment in order to determine waiver or alternative care program eligibility,
187.19 must be visited by a long-term care consultation team within 20 calendar days after the date
187.20 on which an assessment was requested or recommended. Upon statewide implementation
187.21 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
187.22 requesting personal care assistance services ~~and home care nursing. The commissioner shall~~
187.23 ~~provide at least a 90-day notice to lead agencies prior to the effective date of this requirement~~.
187.24 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

188.1 (d) The assessment must be conducted in a face-to-face conversational interview with
188.2 the person being assessed ~~and~~. The person's legal representative must provide input during
188.3 the assessment process and may do so remotely if requested. At the request of the person,
188.4 other individuals may participate in the assessment to provide information on the needs,
188.5 strengths, and preferences of the person necessary to develop a community support plan
188.6 that ensures the person's health and safety. Except for legal representatives or family members
188.7 invited by the person, persons participating in the assessment may not be a provider of

188.8 service or have any financial interest in the provision of services. For persons who are to
188.9 be assessed for elderly waiver customized living or adult day services under section
188.10 256B.0915, with the permission of the person being assessed or the person's designated or
188.11 legal representative, the client's current or proposed provider of services may submit a copy
188.12 of the provider's nursing assessment or written report outlining its recommendations regarding
188.13 the client's care needs. The person conducting the assessment must notify the provider of
188.14 the date by which this information is to be submitted. This information shall be provided
188.15 to the person conducting the assessment prior to the assessment. For a person who is to be
188.16 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
188.17 the person being assessed or the person's designated legal representative, the person's current
188.18 provider of services may submit a written report outlining recommendations regarding the
188.19 person's care needs ~~prepared by a direct service employee with at least 20 hours of service~~
188.20 ~~to that client. The person conducting the assessment or reassessment must notify the provider~~
188.21 ~~of the date by which this information is to be submitted. This information shall be provided~~
188.22 ~~to the person conducting the assessment and the person or the person's legal representative,~~
188.23 ~~and must be considered prior to the finalization of the assessment or reassessment~~ the person
188.24 completed in consultation with someone who is known to the person and has interaction
188.25 with the person on a regular basis. The provider must submit the report at least 60 days
188.26 before the end of the person's current service agreement. The certified assessor must consider
188.27 the content of the submitted report prior to finalizing the person's assessment or reassessment.

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

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

189.4 (g) The written community support plan must include:

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

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

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

189.11 (4) referral information; and

189.12 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

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

190.13 (5) information about Minnesota health care programs;

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

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

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

190.21 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
190.22 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
190.23 (8), and (b), and incorporating the decision regarding the need for institutional level of care
190.24 or the lead agency's final decisions regarding public programs eligibility according to section
190.25 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
190.26 to the person and must visually point out where in the document the right to appeal is stated.

190.27 (k) Face-to-face assessment completed as part of eligibility determination for the
190.28 alternative care, elderly waiver, developmental disabilities, community access for disability
190.29 inclusion, community alternative care, and brain injury waiver programs under sections
190.30 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for
190.31 no more than 60 calendar days after the date of assessment.

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

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

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

191.17 Sec. 23. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

191.18 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
191.19 Prior to a face-to-face reassessment, the certified assessor must review the person's most
191.20 recent assessment. Reassessments must be tailored using the professional judgment of the
191.21 assessor to the person's known needs, strengths, preferences, and circumstances.
191.22 Reassessments provide information to support the person's informed choice and opportunities

191.23 to express choice regarding activities that contribute to quality of life, as well as information
191.24 and opportunity to identify goals related to desired employment, community activities, and
191.25 preferred living environment. Reassessments ~~allow for~~ require a review of the most recent
191.26 assessment, review of the current coordinated service and support plan's effectiveness,
191.27 monitoring of services, and the development of an updated person-centered community
191.28 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
191.29 and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments~~
191.30 reassessments must be conducted annually or as required by federal and state laws and rules.
191.31 For reassessments, the certified assessor and the individual responsible for developing the
191.32 coordinated service and support plan must ensure the continuity of care for the person
191.33 receiving services and complete the updated community support plan and the updated
191.34 coordinated service and support plan no more than 60 days from the reassessment visit.

192.1 (b) The commissioner shall develop mechanisms for providers and case managers to
192.2 share information with the assessor to facilitate a reassessment and support planning process
192.3 tailored to the person's current needs and preferences.

192.4 Sec. 24. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision
192.5 to read:

192.6 Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by
192.7 federal law, the county agency is not required to conduct or arrange for an annual needs
192.8 reassessment by a certified assessor. The case manager who works on behalf of the person
192.9 to identify the person's needs and to minimize the impact of the disability on the person's
192.10 life must instead develop a person-centered service plan based on the person's assessed
192.11 needs and preferences. The person-centered service plan must be reviewed annually for
192.12 persons with developmental disabilities who are receiving only case management services
192.13 under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an
192.14 assessment under this section.

192.15 Sec. 25. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

192.16 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
192.17 including timelines for when assessments need to be completed, required to provide the
192.18 services in this section and shall implement integrated solutions to automate the business
192.19 processes to the extent necessary for community support plan approval, reimbursement,
192.20 program planning, evaluation, and policy development.

192.21 (b) The commissioner of human services shall work with lead agencies responsible for
192.22 conducting long-term consultation services to modify the MnCHOICES application and
192.23 assessment policies to create efficiencies while ensuring federal compliance with medical
192.24 assistance and long-term services and supports eligibility criteria.

192.25 (c) The commissioner shall work with lead agencies responsible for conducting long-term
192.26 consultation services to develop a set of measurable benchmarks sufficient to demonstrate
192.27 quarterly improvement in the average time per assessment and other mutually agreed upon

192.28 measures of increasing efficiency. The commissioner shall collect data on these benchmarks
192.29 and provide to the lead agencies and the chairs and ranking minority members of the
192.30 legislative committees with jurisdiction over human services an annual trend analysis of
192.31 the data in order to demonstrate the commissioner's compliance with the requirements of
192.32 this subdivision.

269.13 Sec. 37. Minnesota Statutes 2018, section 256B.0915, subdivision 3a, is amended to read:

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

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

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

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

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

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

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

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

270.25 (f) The commissioner shall approve an exception to the monthly case mix budget cap
270.26 in paragraph (a) to account for the additional cost of providing enhanced rate personal care
270.27 assistance services under section 256B.0659 or 256B.85. The exception shall not exceed
270.28 107.5 percent of the budget otherwise available to the individual. The exception must be
270.29 reapproved on an annual basis at the time of a participant's annual reassessment.

270.30 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
270.31 whichever is later. The commissioner of human services shall notify the revisor of statutes
270.32 when federal approval is obtained.

193.1 Sec. 26. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

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

193.5 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
193.6 ~~manager receives the assessment information and written community support plan as~~
193.7 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
193.8 established by the commissioner. The timeline for completing the community support plan
193.9 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
193.10 not exceed 60 calendar days from the assessment visit;

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

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

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

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

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

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

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

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

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

194.1 Sec. 27. Minnesota Statutes 2018, section 256B.0915, subdivision 10, is amended to read:

194.2 Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner
194.3 shall adjust the elderly waiver capitation payment rates for managed care organizations paid
194.4 under section 256B.69, subdivisions 6b and 23, to reflect the maximum service rate limits
194.5 for customized living services and 24-hour customized living services under subdivisions
194.6 3e and 3h, and the rate adjustment under subdivision 18. Medical assistance rates paid to
194.7 customized living providers by managed care organizations under this section shall not
194.8 exceed the maximum service rate limits and component rates as determined by the
194.9 commissioner under subdivisions 3e and 3h, plus any rate adjustment under subdivision
194.10 18.

194.11 Sec. 28. Minnesota Statutes 2018, section 256B.0915, is amended by adding a subdivision
194.12 to read:

194.13 Subd. 18. **Disproportionate share establishment customized living rate**
194.14 **adjustment.** (a) For purposes of this section, "designated disproportionate share
194.15 establishment" means a housing with services establishment registered under chapter 144D
194.16 that meets the requirements of paragraph (d).

194.17 (b) A housing with services establishment registered under chapter 144D may apply
194.18 annually between June 1 and June 15 to the commissioner to be designated as a
194.19 disproportionate share establishment. The applying housing with services establishment
194.20 must apply to the commissioner in the manner determined by the commissioner. The applying
194.21 housing with services establishment must document as a percentage the census of elderly
194.22 waiver participants residing in the establishment on May 31 of the year of application.

194.23 (c) Only a housing with services establishment registered under chapter 144D with a
194.24 census of at least 50 percent elderly waiver participants on May 31 of the application year
194.25 is eligible under this section for designation as a disproportionate share establishment.

194.26 (d) By June 30, the commissioner shall designate as a disproportionate share establishment
194.27 any housing with services establishment that complies with the requirements of paragraph
194.28 (b) and meets the eligibility criteria described in paragraph (c).

194.29 (e) A designated disproportionate share establishment's customized living rate adjustment
194.30 is the sum of 0.83 plus the product of 0.36 multiplied by the percentage of elderly waiver
194.31 participants residing in the establishment as reported on the establishment's most recent
194.32 application for designation as a disproportionate share establishment. No establishment may
194.33 receive a customized living rate adjustment greater than 1.10.

195.1 (f) The commissioner shall multiply the customized living rate and 24-hour customized
195.2 living rate for a designated disproportionate share establishment by the amount determined
195.3 under paragraph (e).

195.4 (g) The value of the rate adjustment under paragraph (e) shall not be included in an
195.5 individual elderly waiver client's monthly case mix budget cap.

195.6 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
195.7 whichever is later, and applies to rates paid on or after January 1, 2021. The commissioner
195.8 of human services shall inform the revisor of statutes when federal approval is obtained.

195.9 Sec. 29. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

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

195.13 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
195.14 ~~manager receives the assessment information and written community support plan as~~
195.15 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
195.16 established by the commissioner. The timeline for completing the community support plan
195.17 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
195.18 not exceed 60 calendar days from the assessment visit;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

196.22 Sec. 30. Minnesota Statutes 2018, section 256B.092, is amended by adding a subdivision
196.23 to read:

196.24 Subd. 12a. **Developmental disabilities waiver growth limit.** The commissioner shall
196.25 limit the total number of people receiving developmental disabilities waiver services to the
196.26 number of people receiving developmental disabilities waiver services on June 30, 2019.
196.27 The commissioner shall only add new recipients when an existing recipient permanently
196.28 leaves the program. The commissioner shall reserve capacity, within enrollment limits, to
196.29 re-enroll persons who temporarily discontinue and then resume waiver services within 90
196.30 days of the date that services were discontinued. When adding a new recipient, the

196.31 commissioner shall target persons who meet the priorities for accessing waiver services
196.32 identified in subdivision 12. The allocation limits include conversions from intermediate
197.1 care facilities for persons with developmental disabilities unless capacity at the facility is
197.2 permanently converted to home and community-based services through the developmental
197.3 disabilities waiver.

197.4 Sec. 31. Minnesota Statutes 2018, section 256B.0921, is amended to read:
197.5 256B.0921 HOME AND COMMUNITY-BASED SERVICES ~~INCENTIVE~~
197.6 INNOVATION POOL.

197.7 The commissioner of human services shall develop an initiative to provide incentives
197.8 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
197.9 competitive employment for youth under age 25 upon their graduation from school; (3)
197.10 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
197.11 The commissioner shall seek requests for proposals and shall contract with one or more
197.12 entities to provide incentive payments for meeting identified outcomes.

271.1 Sec. 38. Minnesota Statutes 2018, section 256B.0949, is amended by adding a subdivision
271.2 to read:

271.3 Subd. 16a. **Background studies.** The requirements for background studies under this
271.4 section shall be met by an early intensive developmental and behavioral intervention services
271.5 agency through the commissioner's NETStudy system as provided under sections 245C.03,
271.6 subdivision 13, and 245C.10, subdivision 14.

ARTICLE 2:

108.19 Sec. 33. Minnesota Statutes 2018, section 256B.14, subdivision 2, is amended to read:

108.20 Subd. 2. **Actions to obtain payment.** (a) The state agency shall promulgate rules to
108.21 determine the ability of responsible relatives to contribute partial or complete payment or
108.22 repayment of medical assistance furnished to recipients for whom they are responsible. All
108.23 medical assistance exclusions shall be allowed, and a resource limit of $10,000 for
108.24 nonexcluded resources shall be implemented. Above these limits, a contribution of one-third
108.25 of the excess resources shall be required. These rules shall not require payment or repayment
108.26 when payment would cause undue hardship to the responsible relative or that relative's
108.27 immediate family. These rules shall be consistent with the requirements of section 252.27
108.28 for parents of children whose eligibility for medical assistance was determined without
108.29 deeming of the parents' resources and income. The county agency shall give the responsible
108.30 relative notice of the amount of the payment or repayment. If the state agency or county
108.31 agency finds that notice of the payment obligation was given to the responsible relative,
108.32 but that the relative failed or refused to pay, a cause of action exists against the responsible
109.1 relative for that portion of medical assistance granted after notice was given to the responsible
109.2 relative, which the relative was determined to be able to pay.

109.3 The action may be brought by the state agency or the county agency in the county where 109.4 assistance was granted, for the assistance, together with the costs of disbursements incurred 109.5 due to the action.

109.6 In addition to granting the county or state agency a money judgment, the court may, 109.7 upon a motion or order to show cause, order continuing contributions by a responsible 109.8 relative found able to repay the county or state agency. The order shall be effective only 109.9 for the period of time during which the recipient receives medical assistance from the county 109.10 or state agency.

109.11 (b) Beginning July 1, 2021, the rules described in paragraph (a) shall not apply to parents 109.12 of children whose eligibility for medical assistance was determined without deeming of the 109.13 parents' resources and income under the TEFRA option or for the purposes of accessing 109.14 home and community-based waiver services.

ARTICLE 5:

197.13 Sec. 32. Minnesota Statutes 2018, section 256B.49, is amended by adding a subdivision 197.14 to read:

197.15 Subd. 11b. **Community access for disability inclusion waiver growth limit.** The 197.16 commissioner shall limit the total number of people receiving community access for disability 197.17 inclusion waiver services to the number of people receiving community access for disability 197.18 inclusion waiver services on June 30, 2019. The commissioner shall only add new recipients 197.19 when an existing recipient permanently leaves the program. The commissioner shall reserve 197.20 capacity, within enrollment limits, to re-enroll persons who temporarily discontinue and 197.21 then resume waiver services within 90 days of the date that services were discontinued. 197.22 When adding a new recipient, the commissioner shall target individuals who meet the 197.23 priorities for accessing waiver services identified in subdivision 11a. The allocation limits 197.24 includes conversions and diversions from nursing facilities.

197.25 Sec. 33. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

197.26 Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver 197.27 shall be provided case management services by qualified vendors as described in the federally 197.28 approved waiver application. The case management service activities provided must include:

197.29 (1) finalizing the written coordinated service and support plan within ~~ten working days~~ 197.30 ~~after the case manager receives the plan from the certified assessor~~ the timelines established 197.31 by the commissioner. The timeline for completing the community support plan under section 198.1 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 198.2 60 calendar days from the assessment visit;

198.3 (2) informing the recipient or the recipient's legal guardian or conservator of service 198.4 options;

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

198.8 (4) assisting the recipient to access services and assisting with appeals under section
198.9 256.045; and

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

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

198.15 (1) finalizing the coordinated service and support plan;

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

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

198.19 (c) Case management services must be provided by a public or private agency that is
198.20 enrolled as a medical assistance provider determined by the commissioner to meet all of
198.21 the requirements in the approved federal waiver plans. Case management services must not
198.22 be provided to a recipient by a private agency that has any financial interest in the provision
198.23 of any other services included in the recipient's coordinated service and support plan. For
198.24 purposes of this section, "private agency" means any agency that is not identified as a lead
198.25 agency under section 256B.0911, subdivision 1a, paragraph (e).

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

199.1 (1) phasing out the use of prohibited procedures;

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

199.4 (3) accomplishment of identified outcomes.

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

199.8 Sec. 34. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

199.9 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
199.10 conducted by certified assessors according to section 256B.0911, subdivision 2b. The
199.11 certified assessor, with the permission of the recipient or the recipient's designated legal
199.12 representative, may invite other individuals to attend the assessment. With the permission
199.13 of the recipient or the recipient's designated legal representative, the recipient's current
199.14 provider of services may submit a written report outlining their recommendations regarding
199.15 the recipient's care needs prepared by a direct service employee ~~with at least 20 hours of~~
199.16 ~~service to that client. The certified assessor must notify the provider of the date by which~~
199.17 ~~this information is to be submitted. This information shall be provided to the certified~~
199.18 ~~assessor and the person or the person's legal representative and must be considered prior to~~
199.19 ~~the finalization of the assessment or reassessment~~ who is familiar with the person. The
199.20 provider must submit the report at least 60 days before the end of the person's current service
199.21 agreement. The certified assessor must consider the content of the submitted report prior
199.22 to finalizing the person's assessment or reassessment.

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

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

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

ARTICLE 1:

50.24 Sec. 46. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
50.25 to read:

50.26 Subd. 1a. **Annual labor market reporting.** (a) As determined by the commissioner, a
50.27 provider of home and community-based services for the elderly under sections 256B.0913
50.28 and 256B.0915, home and community-based services for people with developmental
50.29 disabilities under section 256B.092, and home and community-based services for people
50.30 with disabilities under section 256B.49 shall submit data to the commissioner on the
50.31 following:

50.32 (1) number of direct-care staff;

50.33 (2) wages of direct-care staff;

51.1 (3) hours worked by direct-care staff;

51.2 (4) overtime wages of direct-care staff;

51.3 (5) overtime hours worked by direct-care staff;

51.4 (6) benefits paid and accrued by direct-care staff;

51.5 (7) direct-care staff retention rates;

51.6 (8) direct-care staff job vacancies;

51.7 (9) amount of travel time paid;

51.8 (10) program vacancy rates; and

51.9 (11) other related data requested by the commissioner.

51.10 (b) The commissioner may adjust reporting requirements for a self-employed direct-care
51.11 staff.

51.12 (c) For the purposes of this subdivision, "direct-care staff" means employees, including
51.13 self-employed individuals and individuals directly employed by a participant in a
51.14 consumer-directed service delivery option, providing direct service provision to people
51.15 receiving services under this section. Direct-care staff does not include executive, managerial,
51.16 or administrative staff.

51.17 (d) This subdivision also applies to a provider of personal care assistance services under
51.18 section 256B.0625, subdivision 19a; community first services and supports under section
51.19 256B.85; nursing services and home health services under section 256B.0625, subdivision
51.20 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and
51.21 habilitation services for residents of intermediate care facilities for persons with
51.22 developmental disabilities under section 256B.501.

51.23 (e) This subdivision also applies to financial management services providers for
51.24 participants who directly employ direct-care staff through consumer support grants under
51.25 section 256.476; the personal care assistance choice program under section 256B.0657,
51.26 subdivisions 18 to 20; community first services and supports under section 256B.85; and
51.27 the consumer-directed community supports option available under the alternative care
51.28 program, the brain injury waiver, the community alternative care waiver, the community
51.29 alternatives for disabled individuals waiver, the developmental disabilities waiver, the
51.30 elderly waiver, and the Minnesota senior health option, except financial management services
51.31 providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

52.1 (f) The commissioner shall ensure that data submitted under this subdivision is not
52.2 duplicative of data submitted under any other section of this chapter or any other chapter.

52.3 (g) A provider shall submit the data annually on a date specified by the commissioner.
52.4 The commissioner shall give a provider at least 30 calendar days to submit the data. If a

52.5 provider fails to submit the requested data by the date specified by the commissioner, the
52.6 commissioner may delay medical assistance reimbursement until the requested data is
52.7 submitted.

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

52.10 (i) The commissioner shall analyze data annually for workforce assessments and how
52.11 the data impact service access.

52.12 **EFFECTIVE DATE.** This section is effective January 1, 2020.

271.7 Sec. 39. Minnesota Statutes 2018, section 256B.4913, subdivision 4a, is amended to read:

271.8 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
271.9 "implementation period" means the period beginning January 1, 2014, and ending on the
271.10 last day of the month in which the rate management system is populated with the data
271.11 necessary to calculate rates for substantially all individuals receiving home and
271.12 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
271.13 means the time period beginning on January 1, 2014, and ending upon the expiration of the
271.14 12-month period defined in paragraph (c), clause (5).

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

271.18 (1) for a day service recipient who was not authorized to receive these waiver services
271.19 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
271.20 changed providers on or after January 1, 2014, the historical rate must be the weighted
271.21 average authorized rate for the provider number in the county of service, effective December
271.22 1, 2013; or

271.23 (2) for a unit-based service with programming or a unit-based service without
271.24 programming recipient who was not authorized to receive these waiver services prior to
271.25 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
271.26 providers on or after January 1, 2014, the historical rate must be the weighted average
271.27 authorized rate for each provider number in the county of service, effective December 1,
271.28 2013; or

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

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

272.3 (1) 0.5 percent from the historical rate for the implementation period;

272.4 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
272.5 following the time period of clause (1);

272.6 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
272.7 following the time period of clause (2);

272.8 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
272.9 following the time period of clause (3);

272.10 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
272.11 following the time period of clause (4); and

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

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

272.19 (d) The commissioner shall review all changes to rates that were in effect on December
272.20 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
272.21 unit utilization on an annual basis as those in effect on October 31, 2013.

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

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

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

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

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

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

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

House Language H2414-2

273.7 Sec. 40. Minnesota Statutes 2018, section 256B.4913, subdivision 5, is amended to read:

273.8 Subd. 5. **Stakeholder consultation and county training.** (a) The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, to assist in the ~~full implementation~~ ongoing administration of the ~~new~~ rate payment system and to make pertinent information available to the public through the department's website.

273.14 (b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section and section 256B.4914.

273.17 (c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual shall be consistent with this section and section 256B.4914, and shall be accessible to all stakeholders including recipients, representatives of recipients, county or tribal agencies, and license holders.

273.21 (d) The commissioner shall not defer to the county or tribal agency on matters of technical application of the rate-setting framework, and a county or tribal agency shall not set rates in a manner that conflicts with this section or section 256B.4914.

273.24 **EFFECTIVE DATE.** This section is effective January 1, 2020.

273.25 Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

273.29 (c) "Comparable occupations" means the occupations, excluding direct care staff, as represented by the Bureau of Labor Statistics standard occupational classification codes that have the same classification for:

274.1 (1) typical education needed for entry;

274.2 (2) work experience in a related occupation; and

274.3 (3) typical on-the-job training competency as the most predominant classification for direct care staff.

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

Senate Language UEH2414-1

ARTICLE 5:

200.4 Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

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

House Language H2414-2

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

274.10 (f) "Direct care staff" means employees providing direct service to people receiving
274.11 services under this section. Direct care staff excludes executive, managerial, and
274.12 administrative staff.

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

274.16 ~~(f)~~ (h) "Individual staffing" means the time spent as a one-to-one interaction specific to
274.17 an individual recipient by staff to provide direct support and assistance with activities of
274.18 daily living, instrumental activities of daily living, and training to participants, and is based
274.19 on the requirements in each individual's coordinated service and support plan under section
274.20 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
274.21 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
274.22 needs must also be considered.

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

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

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

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

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

275.3 ~~(l)~~ (n) "Shared staffing" means time spent by employees, not defined under paragraph
275.4 (f), providing or available to provide more than one individual with direct support and
275.5 assistance with activities of daily living as defined under section 256B.0659, subdivision
275.6 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
275.7 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
275.8 training to participants, and is based on the requirements in each individual's coordinated
275.9 service and support plan under section 245D.02, subdivision 4b; any coordinated service
275.10 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
275.11 provider observation of an individual's service need. Total shared staffing hours are divided
275.12 proportionally by the number of individuals who receive the shared service provisions.

Senate Language UEH2414-1

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

200.13 (e) "Direct care staff" means employees providing direct services to an individual
200.14 receiving services under this section. Direct care staff excludes executive, managerial, or
200.15 administrative staff.

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

200.19 ~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to
200.20 an individual recipient by staff to provide direct support and assistance with activities of
200.21 daily living, instrumental activities of daily living, and training to participants, and is based
200.22 on the requirements in each individual's coordinated service and support plan under section
200.23 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
200.24 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
200.25 needs must also be considered.

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

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

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

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

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

201.6 ~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
201.7 (f), providing or available to provide more than one individual with direct support and
201.8 assistance with activities of daily living as defined under section 256B.0659, subdivision
201.9 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
201.10 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
201.11 training to participants, and is based on the requirements in each individual's coordinated
201.12 service and support plan under section 245D.02, subdivision 4b; any coordinated service
201.13 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
201.14 provider observation of an individual's service need. Total shared staffing hours are divided
201.15 proportionally by the number of individuals who receive the shared service provisions.

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

275.17 ~~(n)~~ (p) "Unit of service" means the following:

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

275.21 (2) for day services under subdivision 7:

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

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

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

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

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

275.31 (iii) for day support services, a unit of service is 15 minutes; and

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

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

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

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

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

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

201.20 ~~(n)~~ (o) "Unit of service" means the following:

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

201.24 (2) for day services under subdivision 7:

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

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

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

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

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

202.3 (iii) for prevocational services, a unit of service is a day or ~~an hour~~ 15 minutes. A day
202.4 unit of service is six or more hours of time spent providing direct service;

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

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

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

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

202.12 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

202.17 (1) 24-hour customized living;

202.18 (2) adult day care;
202.19 (3) adult day care bath;
202.20 ~~(4) behavioral programming;~~
202.21 ~~(5)~~ (4) companion services;
202.22 ~~(6)~~ (5) customized living;
202.23 ~~(7)~~ (6) day training and habilitation;
202.24 (7) employment development services;
202.25 (8) employment exploration services;
202.26 (9) employment support services;
202.27 ~~(8)~~ (10) housing access coordination;
202.28 ~~(9)~~ (11) independent living skills;
202.29 (12) independent living skills specialist services;
203.1 (13) individualized home supports;
203.2 ~~(10)~~ (14) in-home family support;
203.3 ~~(11)~~ (15) night supervision;
203.4 ~~(12)~~ (16) personal support;
203.5 (17) positive support service;
203.6 ~~(13)~~ (18) prevocational services;
203.7 ~~(14)~~ (19) residential care services;
203.8 ~~(15)~~ (20) residential support services;
203.9 ~~(16)~~ (21) respite services;
203.10 ~~(17)~~ (22) structured day services;
203.11 ~~(18)~~ (23) supported employment services;
203.12 ~~(19)~~ (24) supported living services;
203.13 ~~(20)~~ (25) transportation services; and
203.14 ~~(21) individualized home supports;~~
203.15 ~~(22) independent living skills specialist services;~~

276.10 Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 4, is amended to read:

276.11 Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and
276.12 community-based waivered services, including rate exceptions under subdivision 12, are
276.13 set by the rates management system.

276.14 ~~(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a~~
276.15 ~~manner prescribed by the commissioner.~~

276.16 ~~(c)~~ (b) Data and information in the rates management system may be used to calculate
276.17 an individual's rate.

276.18 ~~(d)~~ (c) Service providers, with information from the community support plan and
276.19 oversight by lead agencies, shall provide values and information needed to calculate an
276.20 individual's rate into the rates management system. The determination of service levels must
276.21 be part of a discussion with members of the support team as defined in section 245D.02,
276.22 subdivision 34. This discussion must occur prior to the final establishment of each individual's
276.23 rate. The values and information include:

276.24 (1) shared staffing hours;

276.25 (2) individual staffing hours;

276.26 (3) direct registered nurse hours;

276.27 (4) direct licensed practical nurse hours;

276.28 (5) staffing ratios;

276.29 (6) information to document variable levels of service qualification for variable levels
276.30 of reimbursement in each framework;

277.1 (7) shared or individualized arrangements for unit-based services, including the staffing
277.2 ratio;

277.3 (8) number of trips and miles for transportation services; and

277.4 (9) service hours provided through monitoring technology.

277.5 ~~(e)~~ (d) Updates to individual data must include:

277.6 (1) data for each individual that is updated annually when renewing service plans; and

203.16 ~~(23) employment exploration services;~~

203.17 ~~(24) employment development services;~~

203.18 ~~(25) employment support services; and~~

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

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277.7 (2) requests by individuals or lead agencies to update a rate whenever there is a change
277.8 in an individual's service needs, with accompanying documentation.

277.9 ~~(f)~~ (e) Lead agencies shall review and approve all services reflecting each individual's
277.10 needs, and the values to calculate the final payment rate for services with variables under
277.11 subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and
277.12 the service provider of the final agreed-upon values and rate, and provide information that
277.13 is identical to what was entered into the rates management system. If a value used was
277.14 mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead
277.15 agencies to correct it. Lead agencies must respond to these requests. When responding to
277.16 the request, the lead agency must consider:

277.17 (1) meeting the health and welfare needs of the individual or individuals receiving
277.18 services by service site, identified in their coordinated service and support plan under section
277.19 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

277.20 (2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (h), ~~(i)~~ (n),
277.21 and ~~(m)~~ (o); and meeting or exceeding the licensing standards for staffing required under
277.22 section 245D.09, subdivision 1; and

277.23 (3) meeting the staffing ratio requirements under subdivision 2, paragraph ~~(n)~~ (o), and
277.24 meeting or exceeding the licensing standards for staffing required under section 245D.31.

277.25 **EFFECTIVE DATE.** This section is effective January 1, 2020.

277.26 Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

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

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

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

278.8 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
278.9 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
278.10 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
278.11 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
278.12 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

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203.21 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

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

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

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

204.5 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
204.6 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
204.7 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
204.8 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
204.9 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

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278.13 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
278.14 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
278.15 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

278.16 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
278.17 for large employers, except in a family foster care setting, the wage is 36 percent of the
278.18 minimum wage in Minnesota for large employers;

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

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

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

278.25 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
278.26 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
278.27 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
278.28 21-1093);

278.29 (8) for housing access coordination staff, 100 percent of the median wage for community
278.30 and social services specialist (SOC code 21-1099);

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

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

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

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

279.14 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
279.15 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
279.16 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
279.17 21-1093);

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204.10 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
204.11 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
204.12 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

204.13 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
204.14 for large employers, except in a family foster care setting, the wage is 36 percent of the
204.15 minimum wage in Minnesota for large employers;

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

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

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

204.22 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
204.23 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
204.24 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
204.25 21-1093);

204.26 (8) for housing access coordination staff, 100 percent of the median wage for community
204.27 and social services specialist (SOC code 21-1099);

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

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

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

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

205.11 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
205.12 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
205.13 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
205.14 21-1093);

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279.18 (14) for employment support services staff, 50 percent of the median wage for 279.19 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for 279.20 community and social services specialist (SOC code 21-1099);	205.15 (14) for employment support services staff, 50 percent of the median wage for 205.16 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for 205.17 community and social services specialist (SOC code 21-1099);
279.21 (15) for employment exploration services staff, 50 percent of the median wage for 279.22 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for 279.23 community and social services specialist (SOC code 21-1099);	205.18 (15) for employment exploration services staff, 50 percent of the median wage for 205.19 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for 205.20 community and social services specialist (SOC code 21-1099);
279.24 (16) for employment development services staff, 50 percent of the median wage for 279.25 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent 279.26 of the median wage for community and social services specialist (SOC code 21-1099);	205.21 (16) for employment development services staff, 50 percent of the median wage for 205.22 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent 205.23 of the median wage for community and social services specialist (SOC code 21-1099);
279.27 (17) for adult companion staff, 50 percent of the median wage for personal and home 279.28 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant 279.29 (SOC code 31-1014);	205.24 (17) for adult companion staff, 50 percent of the median wage for personal and home 205.25 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant 205.26 (SOC code 31-1014);
279.30 (18) for night supervision staff, 20 percent of the median wage for home health aide 279.31 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide 279.32 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 280.1 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); 280.2 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);	205.27 (18) for night supervision staff, 20 percent of the median wage for home health aide 205.28 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide 205.29 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 205.30 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); 205.31 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);
280.3 (19) for respite staff, 50 percent of the median wage for personal and home care aide 280.4 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 280.5 31-1014);	206.1 (19) for respite staff, 50 percent of the median wage for personal and home care aide 206.2 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 206.3 31-1014);
280.6 (20) for personal support staff, 50 percent of the median wage for personal and home 280.7 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant 280.8 (SOC code 31-1014);	206.4 (20) for personal support staff, 50 percent of the median wage for personal and home 206.5 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant 206.6 (SOC code 31-1014);
280.9 (21) for supervisory staff, 100 percent of the median wage for community and social 280.10 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior 280.11 professional, behavior analyst, and behavior specialists, which is 100 percent of the median 280.12 wage for clinical counseling and school psychologist (SOC code 19-3031);	206.7 (21) for supervisory staff, 100 percent of the median wage for community and social 206.8 services specialist (SOC code 21-1099), with the exception of the supervisor of behavior 206.9 professional, behavior analyst, and behavior specialists, which is 100 percent of the median 206.10 wage for clinical counseling and school psychologist (SOC code 19-3031);
280.13 (22) for registered nurse staff, 100 percent of the median wage for registered nurses 280.14 (SOC code 29-1141); and	206.11 (22) for registered nurse staff, 100 percent of the median wage for registered nurses 206.12 (SOC code 29-1141); and
280.15 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed 280.16 practical nurses (SOC code 29-2061).	206.13 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed 206.14 practical nurses (SOC code 29-2061).
	206.15 (b) The commissioner shall adjust the base wage index in paragraph (j) with a competitive 206.16 workforce factor of 4.7 percent to provide increased compensation to direct care staff. A 206.17 provider shall use the additional revenue from the competitive workforce factor to increase 206.18 wages for or to improve benefits provided to direct care staff.
	206.19 (c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall 206.20 report to the chairs and ranking minority members of the legislative committees and divisions

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	206.21 with jurisdiction over health and human services policy and finance an analysis of the 206.22 competitive workforce factor. The report shall include recommendations to adjust the 206.23 competitive workforce factor using (1) the most recently available wage data by SOC code 206.24 of the weighted average wage for direct care staff for residential services and direct care 206.25 staff for day services; (2) the most recently available wage data by SOC code of the weighted 206.26 average wage of comparable occupations; and (3) labor market data as required under 206.27 subdivision 10a, paragraph (g). The commissioner shall not recommend in any biennial 206.28 report an increase or decrease of the competitive workforce factor by more than two 206.29 percentage points from the current value. If, after a biennial analysis for the next report, the 206.30 competitive workforce factor is less than or equal to zero, the commissioner shall recommend 206.31 a competitive workforce factor of zero.
280.17 (b) Component values for residential support services are:	206.32 ~~(b)~~ (d) Component values for residential support services are:
280.18 (1) competitive workforce factor: 4.7 percent;	
280.19 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;	206.33 (1) supervisory span of control ratio: 11 percent;
280.20 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;	207.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
280.21 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;	207.2 (3) employee-related cost ratio: 23.6 percent;
280.22 ~~(4)~~ (5) general administrative support ratio: 13.25 percent;	207.3 (4) general administrative support ratio: 13.25 percent;
280.23 ~~(5)~~ (6) program-related expense ratio: 1.3 percent; and	207.4 (5) program-related expense ratio: 1.3 percent; and
280.24 ~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.	207.5 (6) absence and utilization factor ratio: 3.9 percent.
280.25 (c) Component values for family foster care are:	207.6 ~~(c)~~ (e) Component values for family foster care are:
280.26 (1) competitive workforce factor: 4.7 percent;	
280.27 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;	207.7 (1) supervisory span of control ratio: 11 percent;
280.28 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;	207.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
280.29 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;	207.9 (3) employee-related cost ratio: 23.6 percent;
280.30 ~~(4)~~ (5) general administrative support ratio: 3.3 percent;	207.10 (4) general administrative support ratio: 3.3 percent;
281.1 ~~(5)~~ (6) program-related expense ratio: 1.3 percent; and	207.11 (5) program-related expense ratio: 1.3 percent; and
281.2 ~~(6)~~ (7) absence factor: 1.7 percent.	207.12 (6) absence factor: 1.7 percent.
281.3 (d) Component values for day services for all services are:	207.13 ~~(d)~~ (f) Component values for day services for all services are:
281.4 (1) competitive workforce factor: 4.7 percent;	
281.5 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;	207.14 (1) supervisory span of control ratio: 11 percent;
281.6 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;	207.15 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

House line	House Language H2414-2	Senate line	Senate Language UEH2414-1
281.7	~~(3)~~ (4) employee-related cost ratio: 23.6 percent;	207.16	(3) employee-related cost ratio: 23.6 percent;
281.8	~~(4)~~ (5) program plan support ratio: 5.6 percent;	207.17	(4) program plan support ratio: 5.6 percent;
281.9	~~(5)~~ (6) client programming and support ratio: ten percent;	207.18	(5) client programming and support ratio: ten percent;
281.10	~~(6)~~ (7) general administrative support ratio: 13.25 percent;	207.19	(6) general administrative support ratio: 13.25 percent;
281.11	~~(7)~~ (8) program-related expense ratio: 1.8 percent; and	207.20	(7) program-related expense ratio: 1.8 percent; and
281.12	~~(8)~~ (9) absence and utilization factor ratio: 9.4 percent.	207.21	(8) absence and utilization factor ratio: 9.4 percent.
281.13	(e) Component values for unit-based services with programming are:	207.22	~~(e)~~ (g) Component values for unit-based services with programming are:
281.14	(1) competitive workforce factor: 4.7 percent;		
281.15	~~(1)~~ (2) supervisory span of control ratio: 11 percent;	207.23	(1) supervisory span of control ratio: 11 percent;
281.16	~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;	207.24	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
281.17	~~(3)~~ (4) employee-related cost ratio: 23.6 percent;	207.25	(3) employee-related cost ratio: 23.6 percent;
281.18	~~(4)~~ (5) program plan supports ratio: 15.5 percent;	207.26	(4) program plan supports ratio: 15.5 percent;
281.19	~~(5)~~ (6) client programming and supports ratio: 4.7 percent;	207.27	(5) client programming and supports ratio: 4.7 percent;
281.20	~~(6)~~ (7) general administrative support ratio: 13.25 percent;	208.1	(6) general administrative support ratio: 13.25 percent;
281.21	~~(7)~~ (8) program-related expense ratio: 6.1 percent; and	208.2	(7) program-related expense ratio: 6.1 percent; and
281.22	~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.	208.3	(8) absence and utilization factor ratio: 3.9 percent.
281.23	(f) Component values for unit-based services without programming except respite are:	208.4 208.5	~~(f)~~ (h) Component values for unit-based services without programming except respite are:
281.24	(1) competitive workforce factor: 4.7 percent;		
281.25	~~(1)~~ (2) supervisory span of control ratio: 11 percent;	208.6	(1) supervisory span of control ratio: 11 percent;
281.26	~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;	208.7	(2) employee vacation, sick, and training allowance ratio: 8.71 percent;
281.27	~~(3)~~ (4) employee-related cost ratio: 23.6 percent;	208.8	(3) employee-related cost ratio: 23.6 percent;
282.1	~~(4)~~ (5) program plan support ratio: 7.0 percent;	208.9	(4) program plan support ratio: 7.0 percent;
282.2	~~(5)~~ (6) client programming and support ratio: 2.3 percent;	208.10	(5) client programming and support ratio: 2.3 percent;
282.3	~~(6)~~ (7) general administrative support ratio: 13.25 percent;	208.11	(6) general administrative support ratio: 13.25 percent;
282.4	~~(7)~~ (8) program-related expense ratio: 2.9 percent; and	208.12	(7) program-related expense ratio: 2.9 percent; and
282.5	~~(8)~~ (9) absence and utilization factor ratio: 3.9 percent.	208.13	(8) absence and utilization factor ratio: 3.9 percent.
282.6	(g) Component values for unit-based services without programming for respite are:	208.14	~~(g)~~ (i) Component values for unit-based services without programming for respite are:

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282.7 (1) competitive workforce factor: 4.7 percent;

282.8 ~~(1)~~ (2) supervisory span of control ratio: 11 percent;

282.9 ~~(2)~~ (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

282.10 ~~(3)~~ (4) employee-related cost ratio: 23.6 percent;

282.11 ~~(4)~~ (5) general administrative support ratio: 13.25 percent;

282.12 ~~(5)~~ (6) program-related expense ratio: 2.9 percent; and

282.13 ~~(6)~~ (7) absence and utilization factor ratio: 3.9 percent.

282.14 (h) ~~On July 1, 2017, the commissioner shall update the base wage index in paragraph~~
282.15 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~
282.16 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~
282.17 ~~values and load them into the rate management system.~~ On July 1, 2022, and every ~~five~~ two
282.18 years thereafter, the commissioner shall update the base wage index in paragraph (a) based
282.19 on the most recently available wage data by SOC from the Bureau of Labor Statistics. The
282.20 commissioner shall publish these updated values and load them into the rate management
282.21 system.

282.22 (i) On July 1, 2022, and July 1, 2024, the commissioner shall increase paragraph (b),
282.23 clause (1); paragraph (c), clause (1); paragraph (d), clause (1); paragraph (e), clause (1);
282.24 paragraph (f), clause (1); and paragraph (g), clause (1), by two percentage points.

282.25 (j) Beginning January 1, 2026, the commissioner shall report to the chairs and ranking
282.26 minority members of the legislative committees and divisions with jurisdiction over health
282.27 and human services policy and finance an analysis of the competitive workforce factor. The
282.28 report must include recommendations to update the competitive workforce factor using:

282.29 (1) the most recently available wage data by SOC code for the weighted average wage
282.30 for direct care staff for residential services and direct care staff for day services;

283.1 (2) the most recently available wage data by SOC code of the weighted average wage
283.2 of comparable occupations; and

283.3 (3) workforce data as required under subdivision 10a, paragraph (g).

283.4 The commissioner shall not recommend an increase or decrease of the competitive workforce
283.5 factor from the current value by more than two percentage points. If, after a biennial analysis
283.6 for the next report, the competitive workforce factor is less than or equal to zero, the
283.7 commissioner shall recommend a competitive workforce factor of zero.

283.8 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
283.9 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
283.10 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
283.11 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~

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

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

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

208.18 (4) general administrative support ratio: 13.25 percent;

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

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

208.21 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~
208.22 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~
208.23 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~
208.24 ~~values and load them into the rate management system.~~ (j) On July 1, 2022, and every ~~five~~
208.25 two years thereafter, the commissioner shall update the base wage index in paragraph (a)
208.26 based on ~~the most recently available~~ wage data by SOC from the Bureau of Labor Statistics
208.27 available 30 months and one day prior to the scheduled update. The commissioner shall
208.28 publish these updated values and load them into the rate management system.

209.1 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
209.2 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
209.3 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
209.4 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~

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~~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.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the ~~date of the~~ data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(l) Upon the implementation of the updates under paragraphs (h) and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(m) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under paragraphs (h) and (k).

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

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, except:

(1) paragraphs (h) and (k) are effective July 1, 2022, or upon federal approval, whichever is later; and

(2) paragraph (l) is effective retroactively from July 1, 2018.

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

Sec. 44. Minnesota Statutes 2018, section 256B.4914, is amended by adding a subdivision to read:

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~~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.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph ~~(d)~~ (f), clause (5); paragraph ~~(e)~~ (g), clause (5); ~~and~~ paragraph ~~(f)~~ (h), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the ~~date of the~~ data ~~most recently~~ available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(l) Upon the implementation of automatic inflation adjustments under paragraphs (j) and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(m) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of automatic inflation adjustments under paragraphs (j) and (k).

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

(o) The commissioner shall update the general administrative support ratio in paragraph (d), clause (4); paragraph (e), clause (4); paragraph (f), clause (6); paragraph (g), clause (6); paragraph (h), clause (6); and paragraph (i), clause (4), for any changes to the annual licensing fee under section 245A.10, subdivision 4, paragraph (b). The commissioner shall adjust these ratios higher or lower by an amount equal in value to the percent change in general administrative support costs attributable to the change in the licensing fee. The commissioner shall publish these updated ratios and load them into the rate management system.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later, except the new paragraphs (b) and (o) are effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

284.8 Subd. 5a. **Direct care staff; compensation.** (a) A provider paid with rates determined under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates determined under subdivision 6 for direct care staff compensation.

284.11 (b) A provider paid with rates determined under subdivision 7 must use a minimum of 45 percent of the revenue generated by rates determined under subdivision 7 for direct care staff compensation.

284.14 (c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum of 55 percent of the revenue generated by rates determined under subdivisions 8 and 9 for direct care staff compensation.

284.17 (d) Applicable compensation under this subdivision includes:

284.18 (1) wages;

284.19 (2) Social Security and Medicare taxes;

284.20 (3) federal unemployment insurance tax;

284.21 (4) state unemployment insurance tax;

284.22 (5) workers' compensation insurance;

284.23 (6) health insurance;

284.24 (7) dental insurance;

284.25 (8) vision insurance;

284.26 (9) life insurance;

284.27 (10) short-term disability insurance;

284.28 (11) long-term disability insurance;

284.29 (12) retirement spending;

285.1 (13) tuition reimbursement;

285.2 (14) wellness programs;

285.3 (15) paid vacation time;

285.4 (16) paid sick time; or

285.5 (17) other items of monetary value provided to direct care staff.

285.6 **EFFECTIVE DATE.** This section is effective January 1, 2020.

285.7 Sec. 45. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

210.5 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

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

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

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

285.16 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the result of clause (2) by the product of one plus the competitive workforce factor in subdivision 5, paragraph (b), clause (1);

285.19 (3) (4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2) (3). This is defined as the customized direct-care rate;

285.22 (4) (5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

285.25 (5) (6) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1) (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

285.29 (6) (7) combine the results of clauses (4) and (5) and (6), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2) (3). This is defined as the direct staffing cost;

286.3 (7) (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3) (4);

286.6 (8) (9) for client programming and supports, the commissioner shall add $2,179; and

286.7 (9) (10) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

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

286.10 (1) subtotal paragraph (a), clauses (7) to (9) (8) to (10), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7) (8);

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

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

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

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

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

210.20 (5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b) (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

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

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

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

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

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

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

286.23 ~~(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must~~
286.24 ~~meet or exceed the days of service used to convert service agreements in effect on December~~
286.25 ~~1, 2013, and must not result in a reduction in spending or service utilization due to conversion~~
286.26 ~~during the implementation period under section 256B.4913, subdivision 4a. If during the~~
286.27 ~~implementation period, an individual's historical rate, including adjustments required under~~
286.28 ~~section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate~~
286.29 ~~determined in this subdivision, the number of days authorized for the individual is 365.~~

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

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

287.4 Sec. 46. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

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

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

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

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

287.13 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
287.14 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
287.15 5;

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

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

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

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

211.17 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
211.18 meet or exceed the days of service used to convert service agreements in effect on December
211.19 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
211.20 during the implementation period under section 256B.4913, subdivision 4a. If during the
211.21 implementation period, an individual's historical rate, including adjustments required under
211.22 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
211.23 determined in this subdivision, the number of days authorized for the individual is 365.

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

211.26 Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

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

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

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

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

212.3 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
212.4 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
212.5 5;

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287.16 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
287.17 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
287.18 5, paragraph (d), clause (1);

287.19 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
287.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
287.21 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

287.22 ~~(4)~~ (5) multiply the number of day program direct staff hours and nursing hours by the
287.23 appropriate staff wage ~~in subdivision 5, paragraph (a), or the customized direct-care rate~~;

287.24 ~~(5)~~ (6) multiply the number of day direct staff hours by the product of the supervision
287.25 span of control ratio in subdivision 5, paragraph (d), clause ~~(1)~~ (2), and the appropriate
287.26 supervision wage in subdivision 5, paragraph (a), clause (21);

287.27 ~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one
287.28 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
287.29 (d), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

287.30 ~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the
287.31 program plan support ratio in subdivision 5, paragraph (d), clause ~~(4)~~ (5);

288.1 ~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus
288.2 the employee-related cost ratio in subdivision 5, paragraph (d), clause ~~(3)~~ (4);

288.3 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by
288.4 one plus the client programming and support ratio in subdivision 5, paragraph (d), clause
288.5 ~~(5)~~ (6);

288.6 ~~(10)~~ (11) for program facility costs, add $19.30 per week with consideration of staffing
288.7 ratios to meet individual needs;

288.8 ~~(11)~~ (12) for adult day bath services, add $7.01 per 15 minute unit;

288.9 ~~(12)~~ (13) this is the subtotal rate;

288.10 ~~(13)~~ (14) sum the standard general and administrative rate, the program-related expense
288.11 ratio, and the absence and utilization factor ratio;

288.12 ~~(14)~~ (15) divide the result of clause ~~(12)~~ (13) by one minus the result of clause ~~(13)~~ (14).
288.13 This is the total payment amount;

288.14 ~~(15)~~ (16) adjust the result of clause ~~(14)~~ (15) by a factor to be determined by the
288.15 commissioner to adjust for regional differences in the cost of providing services;

288.16 ~~(16)~~ (17) for transportation provided as part of day training and habilitation for an
288.17 individual who does not require a lift, add:

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

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

212.11 (5) multiply the number of day direct staff hours by the product of the supervision span
212.12 of control ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (1), and the appropriate supervision
212.13 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

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

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

212.26 (12) this is the subtotal rate;

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

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

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

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

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288.18 (i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without 288.19 a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a 288.20 vehicle with a lift;	213.5 (i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without 213.6 a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a 213.7 vehicle with a lift;
288.21 (ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without 288.22 a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a 288.23 vehicle with a lift;	213.8 (ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without 213.9 a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a 213.10 vehicle with a lift;
288.24 (iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without 288.25 a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a 288.26 vehicle with a lift; or	213.11 (iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without 213.12 a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a 213.13 vehicle with a lift; or
288.27 (iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, 288.28 $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle 288.29 with a lift;	213.14 (iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, 213.15 $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle 213.16 with a lift;
288.30 ~~(17)~~ (18) for transportation provided as part of day training and habilitation for an 288.31 individual who does require a lift, add:	213.17 (17) for transportation provided as part of day training and habilitation for an individual 213.18 who does require a lift, add:
289.1 (i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a 289.2 lift, and $15.05 for a shared ride in a vehicle with a lift;	213.19 (i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a 213.20 lift, and $15.05 for a shared ride in a vehicle with a lift;
289.3 (ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a 289.4 lift, and $28.16 for a shared ride in a vehicle with a lift;	213.21 (ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a 213.22 lift, and $28.16 for a shared ride in a vehicle with a lift;
289.5 (iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a 289.6 lift, and $58.76 for a shared ride in a vehicle with a lift; or	213.23 (iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a 213.24 lift, and $58.76 for a shared ride in a vehicle with a lift; or
289.7 (iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, 289.8 and $80.93 for a shared ride in a vehicle with a lift.	213.25 (iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, 213.26 and $80.93 for a shared ride in a vehicle with a lift.
289.9 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval, 289.10 whichever is later. The commissioner of human services shall notify the revisor of statutes 289.11 when federal approval is obtained.	
289.12 Sec. 47. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:	213.27 Sec. 40. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:
289.13 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based 289.14 services with programming, including ~~behavior programming~~ employment exploration 289.15 services, employment development services, housing access coordination, individualized 289.16 home supports with family training, individualized home supports with training, in-home 289.17 family support, independent living skills training, ~~independent living skills specialist services,~~ 289.18 ~~individualized home supports, hourly supported living services, employment exploration~~ 289.19 ~~services, employment development services, supported employment, and employment~~ 289.20 ~~support~~ and hourly supported living services provided to an individual outside of any day 289.21 or residential service plan must be calculated as follows, unless the services are authorized 289.22 separately under subdivision 6 or 7:	213.28 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based 213.29 services with programming, including behavior programming, housing access coordination, 213.30 in-home family support, independent living skills training, independent living skills specialist 213.31 services, individualized home supports, hourly supported living services, employment 213.32 exploration services, employment development services, supported employment, and 214.1 employment support services provided to an individual outside of any day or residential 214.2 service plan must be calculated as follows, unless the services are authorized separately 214.3 under subdivision 6 or 7:

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

289.24 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
289.25 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
289.26 5;

289.27 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
289.28 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
289.29 5, paragraph (e), clause (1);

289.30 ~~(3)~~ (4) for a recipient requiring customization for deaf and hard-of-hearing language
289.31 accessibility under subdivision 12, add the customization rate provided in subdivision 12
289.32 to the result of clause ~~(2)~~ (3)~~. This is defined as the customized direct-care rate~~;

290.1 ~~(4)~~ (5) multiply the number of direct staff hours by the appropriate staff wage ~~in~~
290.2 ~~subdivision 5, paragraph (a), or the customized direct-care rate~~;

290.3 ~~(5)~~ (6) multiply the number of direct staff hours by the product of the supervision span
290.4 of control ratio in subdivision 5, paragraph (e), clause ~~(1)~~ (2), and the appropriate supervision
290.5 wage in subdivision 5, paragraph (a), clause (21);

290.6 ~~(6)~~ (7) combine the results of clauses ~~(4) and~~ (5) and (6), and multiply the result by one
290.7 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
290.8 (e), clause ~~(2)~~ (3). This is defined as the direct staffing rate;

290.9 ~~(7)~~ (8) for program plan support, multiply the result of clause ~~(6)~~ (7) by one plus the
290.10 program plan supports ratio in subdivision 5, paragraph (e), clause ~~(4)~~ (5);

290.11 ~~(8)~~ (9) for employee-related expenses, multiply the result of clause ~~(7)~~ (8) by one plus
290.12 the employee-related cost ratio in subdivision 5, paragraph (e), clause ~~(3)~~ (4);

290.13 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by
290.14 one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause
290.15 ~~(5)~~ (6);

290.16 ~~(10)~~ (11) this is the subtotal rate;

290.17 ~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense
290.18 ratio, and the absence and utilization factor ratio;

290.19 ~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12).
290.20 This is the total payment amount;

290.21 ~~(13)~~ (14) for supported employment provided in a shared manner, divide the total payment
290.22 amount in clause ~~(12)~~ (13) by the number of service recipients, not to exceed three. For
290.23 employment support services provided in a shared manner, divide the total payment amount
290.24 in clause ~~(12)~~ (13) by the number of service recipients, not to exceed six. For independent
290.25 living skills training and individualized home supports provided in a shared manner, divide

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

214.5 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
214.6 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
214.7 5;

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

214.11 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
214.12 5, paragraph (a), or the customized direct-care rate;

214.13 (5) multiply the number of direct staff hours by the product of the supervision span of
214.14 control ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (1), and the appropriate supervision
214.15 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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

214.25 (10) this is the subtotal rate;

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

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

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

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290.26 the total payment amount in clause (12) (13) by the number of service recipients, not to
290.27 exceed two; and

290.28 (14) (15) adjust the result of clause (13) (14) by a factor to be determined by the
290.29 commissioner to adjust for regional differences in the cost of providing services.

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

291.1 Sec. 48. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

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

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

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

291.11 (3) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the
291.12 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
291.13 5, paragraph (f), clause (1);

291.14 (3) (4) for a recipient requiring customization for deaf and hard-of-hearing language
291.15 accessibility under subdivision 12, add the customization rate provided in subdivision 12
291.16 to the result of clause (2) (3). This is defined as the customized direct care rate;

291.17 (4) (5) multiply the number of direct staff hours by the appropriate staff wage in
291.18 subdivision 5 or the customized direct care rate;

291.19 (5) (6) multiply the number of direct staff hours by the product of the supervision span
291.20 of control ratio in subdivision 5, paragraph (f), clause (1) (2), and the appropriate supervision
291.21 wage in subdivision 5, paragraph (a), clause (21);

291.22 (6) (7) combine the results of clauses (4) and (5) and (6), and multiply the result by one
291.23 plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph
291.24 (f), clause (2) (3). This is defined as the direct staffing rate;

291.25 (7) (8) for program plan support, multiply the result of clause (6) (7) by one plus the
291.26 program plan support ratio in subdivision 5, paragraph (f), clause (4) (5);

291.27 (8) (9) for employee-related expenses, multiply the result of clause (7) (8) by one plus
291.28 the employee-related cost ratio in subdivision 5, paragraph (f), clause (3) (4);

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215.3 total payment amount in clause (12) by the number of service recipients, not to exceed two;
215.4 and

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

215.7 Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

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

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

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

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

215.20 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
215.21 5 or the customized direct care rate;

215.22 (5) multiply the number of direct staff hours by the product of the supervision span of
215.23 control ratio in subdivision 5, paragraph (f) (h), clause (1), and the appropriate supervision
215.24 wage in subdivision 5, paragraph (a), clause (21);

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

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

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

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291.29 ~~(9)~~ (10) for client programming and supports, multiply the result of clause ~~(8)~~ (9) by 291.30 one plus the client programming and support ratio in subdivision 5, paragraph (f), clause 291.31 ~~(5)~~ (6);	216.1 (9) for client programming and supports, multiply the result of clause (8) by one plus 216.2 the client programming and support ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (5);
291.32 ~~(10)~~ (11) this is the subtotal rate;	216.3 (10) this is the subtotal rate;
292.1 ~~(11)~~ (12) sum the standard general and administrative rate, the program-related expense 292.2 ratio, and the absence and utilization factor ratio;	216.4 (11) sum the standard general and administrative rate, the program-related expense ratio, 216.5 and the absence and utilization factor ratio;
292.3 ~~(12)~~ (13) divide the result of clause ~~(10)~~ (11) by one minus the result of clause ~~(11)~~ (12). 292.4 This is the total payment amount;	216.6 (12) divide the result of clause (10) by one minus the result of clause (11). This is the 216.7 total payment amount;
292.5 ~~(13)~~ (14) for respite services, determine the number of day units of service to meet an 292.6 individual's needs;	216.8 (13) for respite services, determine the number of day units of service to meet an 216.9 individual's needs;
292.7 ~~(14)~~ (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor 292.8 Statistics Minnesota-specific rate or rates derived by the commissioner as provided in 292.9 subdivision 5;	216.10 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics 216.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
292.10 (16) except for subdivision 5, paragraph (a), clauses (3) and (21) to (23), multiply the 292.11 result of clause (15) by the product of one plus the competitive workforce factor in 292.12 subdivision 5, paragraph (g), clause (1);	
292.13 ~~(15)~~ (17) for a recipient requiring deaf and hard-of-hearing customization under 292.14 subdivision 12, add the customization rate provided in subdivision 12 to the result of clause 292.15 ~~(14)~~ (16)~~. This is defined as the customized direct care rate~~;	216.12 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 216.13 12, add the customization rate provided in subdivision 12 to the result of clause (14). This 216.14 is defined as the customized direct care rate;
292.16 ~~(16)~~ (18) multiply the number of direct staff hours by the appropriate staff wage ~~in~~ 292.17 ~~subdivision 5, paragraph (a)~~;	216.15 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 216.16 5, paragraph (a);
292.18 ~~(17)~~ (19) multiply the number of direct staff hours by the product of the supervisory 292.19 span of control ratio in subdivision 5, paragraph (g), clause ~~(1)~~ (2), and the appropriate 292.20 supervision wage in subdivision 5, paragraph (a), clause (21);	216.17 (17) multiply the number of direct staff hours by the product of the supervisory span of 216.18 control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (1), and the appropriate supervision 216.19 wage in subdivision 5, paragraph (a), clause (21);
292.21 ~~(18)~~ (20) combine the results of clauses ~~(16)~~ (18) and ~~(17)~~ (19), and multiply the result 292.22 by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, 292.23 paragraph (g), clause ~~(2)~~ (3). This is defined as the direct staffing rate;	216.20 (18) combine the results of clauses (16) and (17), and multiply the result by one plus 216.21 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ 216.22 (i), clause (2). This is defined as the direct staffing rate;
292.24 ~~(19)~~ (21) for employee-related expenses, multiply the result of clause ~~(18)~~ (20) by one 292.25 plus the employee-related cost ratio in subdivision 5, paragraph (g), clause ~~(3)~~ (4);	216.23 (19) for employee-related expenses, multiply the result of clause (18) by one plus the 216.24 employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (3);
292.26 ~~(20)~~ (22) this is the subtotal rate;	216.25 (20) this is the subtotal rate;
292.27 ~~(21)~~ (23) sum the standard general and administrative rate, the program-related expense 292.28 ratio, and the absence and utilization factor ratio;	216.26 (21) sum the standard general and administrative rate, the program-related expense ratio, 216.27 and the absence and utilization factor ratio;
292.29 ~~(22)~~ (24) divide the result of clause ~~(20)~~ (22) by one minus the result of clause ~~(21)~~ (23). 292.30 This is the total payment amount; and	216.28 (22) divide the result of clause (20) by one minus the result of clause (21). This is the 216.29 total payment amount; and

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292.31 ~~(23)~~ (25) adjust the result of clauses ~~(12)~~ (13) and ~~(22)~~ (24) by a factor to be determined
292.32 by the commissioner to adjust for regional differences in the cost of providing services.

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

293.4 Sec. 49. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

293.5 Subd. 10. **Updating payment values and additional information.** ~~(a) From January~~
293.6 ~~1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform~~
293.7 ~~procedures to refine terms and adjust values used to calculate payment rates in this section.~~

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

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

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

293.15 (3) the distinct underlying costs for services provided by a license holder under sections
293.16 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
293.17 by a license holder certified under section 245D.33.

293.18 ~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
293.19 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
293.20 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~
293.21 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
293.22 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
293.23 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
293.24 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
293.25 ~~shall be issued by December 31, 2018.~~

293.26 ~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
293.27 shall begin the review and evaluation of the following values already in subdivisions 6 to
293.28 9, or issues that impact all services, including, but not limited to:

293.29 (1) values for transportation rates;

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

293.31 (3) values for indirect services;

293.32 (4) values for nursing;

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

217.1 Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

217.2 Subd. 10. **Updating payment values and additional information.** ~~(a) From January~~
217.3 ~~1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform~~
217.4 ~~procedures to refine terms and adjust values used to calculate payment rates in this section.~~

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

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

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

217.12 (3) the distinct underlying costs for services provided by a license holder under sections
217.13 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
217.14 by a license holder certified under section 245D.33.

217.15 ~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
217.16 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
217.17 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~
217.18 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
217.19 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
217.20 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
217.21 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
217.22 ~~shall be issued by December 31, 2018.~~

217.23 ~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
217.24 shall begin the review and evaluation of the following values already in subdivisions ~~6~~ 5 to
217.25 9, or issues that impact all services, including, but not limited to:

217.26 (1) values for transportation rates;

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

217.28 (3) values for indirect services;

217.29 (4) values for nursing;

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294.1 (5) values for the facility use rate in day services, and the weightings used in the day 294.2 service ratios and adjustments to those weightings;	217.30 (5) values for the facility use rate in day services, and the weightings used in the day 217.31 service ratios and adjustments to those weightings;
294.3 (6) values for workers' compensation as part of employee-related expenses;	217.32 (6) values for workers' compensation as part of employee-related expenses;
294.4 (7) values for unemployment insurance as part of employee-related expenses;	218.1 (7) values for unemployment insurance as part of employee-related expenses;
294.5 (8) direct care workforce labor market measures;	218.2 (8) direct care workforce labor market measures;
294.6 (9) any changes in state or federal law with a direct impact on the underlying cost of 294.7 providing home and community-based services; and	218.3 (9) any changes in state or federal law with a direct impact on the underlying cost of 218.4 providing home and community-based services; ~~and~~
294.8 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and 294.9 community-based services rates determined under this section.	218.5 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and 218.6 community-based services rates determined under this section~~.~~; and
	218.7 (11) different competitive workforce factors by service.
294.10 ~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members 294.11 of the legislative committees and divisions with jurisdiction over health and human services 294.12 policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) 294.13 and (b) on ~~the following dates:~~	218.8 ~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members 218.9 of the legislative committees and divisions with jurisdiction over health and human services 218.10 policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) 218.11 and (b) on ~~the following dates:~~
294.14 ~~(1) January 15, 2015, with preliminary results and data;~~	218.12 ~~(1) January 15, 2015, with preliminary results and data;~~
294.15 ~~(2) January 15, 2016, with a status implementation update, and additional data and~~ 294.16 ~~summary information;~~	218.13 ~~(2) January 15, 2016, with a status implementation update, and additional data and~~ 218.14 ~~summary information;~~
294.17 ~~(3) January 15, 2017, with the full report; and~~	218.15 ~~(3) January 15, 2017, with the full report; and~~
294.18 ~~(4)~~ January 15, ~~2020~~ 2021, with ~~another~~ a full report, and a full report once every four 294.19 years thereafter.	218.16 ~~(4)~~ January 15, ~~2020~~ 2021, with another full report, and a full report once every four 218.17 years thereafter.
294.20 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~ 294.21 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ 294.22 January 1, 2022, the commissioner shall renew analysis and implement changes to the 294.23 regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h),~~ 294.24 ~~occur~~ once every six years. Prior to implementation, the commissioner shall consult with 294.25 stakeholders on the methodology to calculate the adjustment.	218.18 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~ 218.19 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ 218.20 January 1, 2022, the commissioner shall renew analysis and implement changes to the 218.21 regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h),~~ 218.22 ~~occur~~ once every six years. Prior to implementation, the commissioner shall consult with 218.23 stakeholders on the methodology to calculate the adjustment.
294.26 ~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of 294.27 each year ~~beginning October 1, 2014,~~ containing information detailing legislatively approved 294.28 changes in:	218.24 ~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of 218.25 each year beginning October 1, 2014, containing information detailing legislatively approved 218.26 changes in:
294.29 (1) calculation values including derived wage rates and related employee and 294.30 administrative factors;	218.27 (1) calculation values including derived wage rates and related employee and 218.28 administrative factors;
294.31 (2) service utilization;	218.29 (2) service utilization;
295.1 (3) county and tribal allocation changes; and	218.30 (3) county and tribal allocation changes; and

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295.2 (4) information on adjustments made to calculation values and the timing of those 295.3 adjustments.	219.1 (4) information on adjustments made to calculation values and the timing of those 219.2 adjustments.
295.4 The information in this notice must be effective January 1 of the following year.	219.3 The information in this notice must be effective January 1 of the following year.
295.5 (h) (f) When the available shared staffing hours in a residential setting are insufficient 295.6 to meet the needs of an individual who enrolled in residential services after January 1, 2014, 295.7 or insufficient to meet the needs of an individual with a service agreement adjustment 295.8 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours 295.9 shall be used.	219.4 (h) (f) When the available shared staffing hours in a residential setting are insufficient 219.5 to meet the needs of an individual who enrolled in residential services after January 1, 2014, 219.6 or insufficient to meet the needs of an individual with a service agreement adjustment 219.7 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours 219.8 shall be used.
295.10 (i) The commissioner shall study the underlying cost of absence and utilization for day 295.11 services. Based on the commissioner's evaluation of the data collected under this paragraph, 295.12 the commissioner shall make recommendations to the legislature by January 15, 2018, for 295.13 changes, if any, to the absence and utilization factor ratio component value for day services.	219.9 (i) The commissioner shall study the underlying cost of absence and utilization for day 219.10 services. Based on the commissioner's evaluation of the data collected under this paragraph, 219.11 the commissioner shall make recommendations to the legislature by January 15, 2018, for 219.12 changes, if any, to the absence and utilization factor ratio component value for day services.
295.14 (j) Beginning July 1, 2017, (g) The commissioner shall collect transportation and trip 295.15 information for all day services through the rates management system.	219.13 (j) (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip 219.14 information for all day services through the rates management system.
295.16 (h) The commissioner, in consultation with stakeholders, shall study value-based models 295.17 and outcome-based payment strategies for fee-for-service home and community-based 295.18 services and report to the legislative committees with jurisdiction over the disability waiver 295.19 rate system by October 1, 2020, with recommended strategies to: (1) promote new models 295.20 of care, services, and reimbursement structures that require more efficient use of public 295.21 dollars while improving the outcomes most valued by the individuals served; (2) assist 295.22 clients and their families in evaluating options and stretching individual budget funds; (3) 295.23 support individualized, person-centered planning and individual budget choices; and (4) 295.24 create a broader range of client options geographically or targeted at culturally competent 295.25 models for racial and ethnic minority groups.	219.15 (h) The commissioner, in consultation with stakeholders, shall study value-based models 219.16 and outcome-based payment strategies for fee-for-service home and community-based 219.17 services and report to the legislative committees with jurisdiction over the disability waiver 219.18 rate system by October 1, 2020, with recommended strategies to improve the quality, 219.19 efficiency, and effectiveness of services.
295.26 **EFFECTIVE DATE.** This section is effective the day following final enactment, except 295.27 the amendment to paragraph (f) is effective January 1, 2020.	219.20 **EFFECTIVE DATE.** This section is effective the day following final enactment.
295.28 Sec. 50. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to 295.29 read:	219.21 Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to 219.22 read:
295.30 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure 295.31 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the 295.32 service. As determined by the commissioner, in consultation with stakeholders identified 295.33 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates 296.1 determined under this section must submit requested cost data to the commissioner to support 296.2 research on the cost of providing services that have rates determined by the disability waiver 296.3 rates system. Requested cost data may include, but is not limited to:	219.23 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure 219.24 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the 219.25 service. As determined by the commissioner, in consultation with stakeholders identified 219.26 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates 219.27 determined under this section must submit requested cost data to the commissioner to support 219.28 research on the cost of providing services that have rates determined by the disability waiver 219.29 rates system. Requested cost data may include, but is not limited to:
296.4 (1) worker wage costs;	219.30 (1) worker wage costs;
296.5 (2) benefits paid;	219.31 (2) benefits paid;

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296.6 (3) supervisor wage costs;

296.7 (4) executive wage costs;

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

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

296.10 (7) administrative costs paid;

296.11 (8) program costs paid;

296.12 (9) transportation costs paid;

296.13 (10) vacancy rates; and

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

296.16 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
296.17 year that ended not more than 18 months prior to the submission date. The commissioner
296.18 shall provide each provider a 90-day notice prior to its submission due date. If a provider
296.19 fails to submit required reporting data, the commissioner shall provide notice to providers
296.20 that have not provided required data 30 days after the required submission date, and a second
296.21 notice for providers who have not provided required data 60 days after the required
296.22 submission date. The commissioner shall temporarily suspend payments to the provider if
296.23 cost data is not received 90 days after the required submission date. Withheld payments
296.24 shall be made once data is received by the commissioner.

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

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

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

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219.32 (3) supervisor wage costs;

220.1 (4) executive wage costs;

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

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

220.4 (7) administrative costs paid;

220.5 (8) program costs paid;

220.6 (9) transportation costs paid;

220.7 (10) vacancy rates; and

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

220.10 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
220.11 year that ended not more than 18 months prior to the submission date. The commissioner
220.12 shall provide each provider a 90-day notice prior to its submission due date. If a provider
220.13 fails to submit required reporting data, the commissioner shall provide notice to providers
220.14 that have not provided required data 30 days after the required submission date, and a second
220.15 notice for providers who have not provided required data 60 days after the required
220.16 submission date. The commissioner shall temporarily suspend payments to the provider if
220.17 cost data is not received 90 days after the required submission date. Withheld payments
220.18 shall be made once data is received by the commissioner.

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

220.22 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
220.23 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
220.24 recommendations on component values and inflationary factor adjustments to the chairs
220.25 and ranking minority members of the legislative committees with jurisdiction over human
220.26 services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make
220.27 recommendations in conjunction with reports submitted to the legislature according to
220.28 subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate
220.29 form, and cost data from individual providers shall not be released except as provided for
220.30 in current law.

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

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297.10 (f) Beginning November 1, 2019, providers enrolled to provide services with rates
297.11 determined under this section shall submit labor market data to the commissioner annually,
297.12 including but not limited to:

297.13 (1) number of direct care staff;

297.14 (2) wages of direct care staff;

297.15 (3) overtime wages of direct care staff;

297.16 (4) hours worked by direct care staff;

297.17 (5) overtime hours worked by direct care staff;

297.18 (6) benefits provided to direct care staff;

297.19 (7) direct care staff job vacancies; and

297.20 (8) direct care staff retention rates.

297.21 (g) Beginning February 1, 2020, the commissioner shall publish annual reports on
297.22 provider and state-level labor market data, including but not limited to the data obtained
297.23 under paragraph (f).

297.24 (h) The commissioner shall temporarily suspend payments to the provider if data
297.25 requested under paragraph (f) is not received 90 days after the required submission date.
297.26 The commissioner shall make withheld payments once data is received by the commissioner.

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

297.28 Sec. 51. Minnesota Statutes 2018, section 256B.4914, subdivision 14, is amended to read:

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

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221.3 (f) By December 31, 2020, providers paid with rates calculated under subdivision 5,
221.4 paragraph (b), shall identify additional revenues from the competitive workforce factor and
221.5 prepare a written distribution plan for the revenues. A provider shall make the provider's
221.6 distribution plan available and accessible to all direct care staff for a minimum of one
221.7 calendar year. Upon request, a provider shall submit the written distribution plan to the
221.8 commissioner.

221.9 (g) Providers enrolled to provide services with rates determined under section 256B.4914,
221.10 subdivision 3, shall submit labor market data to the commissioner annually on or before
221.11 November 1, including but not limited to:

221.12 (1) number of direct care staff;

221.13 (2) wages of direct care staff;

221.14 (3) overtime wages of direct care staff;

221.15 (4) hours worked by direct care staff;

221.16 (5) overtime hours worked by direct care staff;

221.17 (6) benefits provided to direct care staff;

221.18 (7) direct care staff job vacancies; and

221.19 (8) direct care staff retention rates.

221.20 (h) The commissioner shall publish annual reports on provider and state-level labor
221.21 market data, including but not limited to the data obtained under paragraph (g).

221.22 (i) The commissioner shall temporarily suspend payments to the provider if data requested
221.23 under paragraph (g) is not received 90 days after the required submission date. Withheld
221.24 payments shall be made once data is received by the commissioner.

221.25 **EFFECTIVE DATE.** This section is effective the day following final enactment except
221.26 paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1,
221.27 2020.

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

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

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

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

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

298.16 (d) Exception requests must include the following information:

298.17 (1) the service needs required by each individual that are not accounted for in subdivisions
298.18 6, 7, 8, and 9;

298.19 (2) the service rate requested and the difference from the rate determined in subdivisions
298.20 6, 7, 8, and 9;

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

298.23 (4) any contingencies for approval.

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

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

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

299.5 (h) The individual disability waiver recipient may appeal any denial of an exception
299.6 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
299.7 256.0451. When the denial of an exception request results in the proposed demission of a
299.8 waiver recipient from a residential or day habilitation program, the commissioner shall issue

299.9 a temporary stay of demission, when requested by the disability waiver recipient, consistent
299.10 with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary
299.11 stay shall remain in effect until the lead agency can provide an informed choice of
299.12 appropriate, alternative services to the disability waiver.

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

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

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

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

299.25 ~~(m) No later than July 1, 2016, the commissioner shall develop and implement, in~~
299.26 ~~consultation with stakeholders, a process to determine eligibility for rate exceptions for~~
299.27 ~~individuals with rates determined under the methodology in section 256B.4913, subdivision~~
299.28 ~~4a. Determination of eligibility for an exception will occur as annual service renewals are~~
299.29 ~~completed.~~

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

299.33 **EFFECTIVE DATE.** This section is effective January 1, 2020.

300.1 Sec. 52. Minnesota Statutes 2018, section 256B.4914, subdivision 15, is amended to read:

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

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

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

221.28 Sec. 44. Minnesota Statutes 2018, section 256B.493, subdivision 1, is amended to read:

221.29 Subdivision 1. **Commissioner's duties; report.** The commissioner of human services
221.30 has the authority to manage statewide licensed corporate foster care or community residential
221.31 settings capacity, including the reduction and realignment of licensed capacity of a current
222.1 foster care or community residential setting to accomplish the consolidation or closure of
222.2 settings. The commissioner shall implement a program for planned closure of licensed
222.3 corporate adult foster care or community residential settings, necessary as a preferred method
222.4 to: (1) respond to the informed decisions of those individuals who want to move out of these
222.5 settings into other types of community settings; and (2) achieve ~~necessary budgetary savings~~
222.6 the reduction of statewide licensed capacity required in section 245A.03, subdivision 7,
222.7 paragraphs (c) and (d). Closure determinations by the commissioner are final and not subject
222.8 to appeal.

222.9 Sec. 45. Minnesota Statutes 2018, section 256B.5013, subdivision 1, is amended to read:

222.10 Subdivision 1. **Variable rate adjustments.** (a) ~~For rate years beginning on or after~~
222.11 ~~October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD
222.12 recipient, the county of financial responsibility may recommend a variable rate to enable
222.13 the facility to meet the individual's increased needs. Variable rate adjustments made under
222.14 this subdivision replace payments for persons with special needs for crisis intervention
222.15 services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a~~
222.16 ~~base rate above the 50th percentile of the statewide average reimbursement rate for a Class~~
222.17 ~~A facility or Class B facility, whichever matches the facility licensure, are not eligible for~~
222.18 ~~a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,~~
222.19 ~~except when approved for purposes established in paragraph (b), clause (1).~~ Once approved,
222.20 variable rate adjustments must continue to remain in place unless there is an identified
222.21 change in need. A review of needed resources must be done at the time of the individual's
222.22 annual support plan meeting. A request to adjust the resources of the individual must be
222.23 submitted if any change in need is identified. Variable rate adjustments approved solely on
222.24 the basis of changes on a developmental disabilities screening document will end June 30,
222.25 2002.

222.26 (b) The county of financial responsibility must act on a variable rate request within 30
222.27 days and notify the initiator of the request of the county's recommendation in writing.

222.28 ~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility
222.29 for increased needs in the following situations:

222.30 (1) a need for resources due to an individual's full or partial retirement from participation
222.31 in a day training and habilitation service when the individual: (i) has reached the age of 65
222.32 or has a change in health condition that makes it difficult for the person to participate in
222.33 day training and habilitation services over an extended period of time because it is medically

223.1 contraindicated; and (ii) has expressed a desire for change through the developmental
223.2 disability screening process under section 256B.092;

223.3 (2) a need for additional resources for intensive short-term programming which is
223.4 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

223.5 (3) a demonstrated medical need that significantly impacts the type or amount of services
223.6 needed by the individual; ~~or~~

223.7 (4) a demonstrated behavioral or cognitive need that significantly impacts the type or
223.8 amount of services needed by the individual~~.~~; or

223.9 ~~(c) The county of financial responsibility must justify the purpose, the projected length~~
223.10 ~~of time, and the additional funding needed for the facility to meet the needs of the individual.~~

223.11 ~~(d) The facility shall provide an annual report to the county case manager on the use of~~
223.12 ~~the variable rate funds and the status of the individual on whose behalf the funds were~~
223.13 ~~approved. The county case manager will forward the facility's report with a recommendation~~
223.14 ~~to the commissioner to approve or disapprove a continuation of the variable rate.~~

223.15 ~~(e) Funds made available through the variable rate process that are not used by the facility~~
223.16 ~~to meet the needs of the individual for whom they were approved shall be returned to the~~
223.17 ~~state.~~

223.18 (5) a demonstrated increased need for staff assistance, changes in the type of staff
223.19 credentials needed, or a need for expert consultation based on assessments conducted prior
223.20 to the annual support plan meeting.

223.21 (d) Variable rate requests must include the following information:

223.22 (1) the service needs change;

223.23 (2) the variable rate requested and the difference from the current rate;

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

223.26 (4) documentation of the expected outcomes to be achieved and the frequency of progress
223.27 monitoring associated with the rate increase.

223.28 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
223.29 whichever is later. The commissioner of human services shall inform the revisor of statutes
223.30 when federal approval is obtained.

224.1 Sec. 46. Minnesota Statutes 2018, section 256B.5013, subdivision 6, is amended to read:

224.2 Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

224.3 (1) make a determination to approve, deny, or modify a request for a variable rate
224.4 adjustment within 30 days of the receipt of the completed application;

224.5 (2) notify the ICF/DD facility and county case manager of the ~~duration and conditions~~
224.6 ~~of variable rate adjustment approvals~~ determination; and

224.7 (3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved
224.8 variable rates.

ARTICLE 1:

56.1 Sec. 52. Minnesota Statutes 2018, section 256B.5014, is amended to read:
56.2 256B.5014 ~~FINANCIAL~~ REPORTING REQUIREMENTS.

56.3 Subdivision 1. **Financial reporting.** All facilities shall maintain financial records and
56.4 shall provide annual income and expense reports to the commissioner of human services
56.5 on a form prescribed by the commissioner no later than April 30 of each year in order to
56.6 receive medical assistance payments. The reports for the reporting year ending December
56.7 31 must include:

56.8 (1) salaries and related expenses, including program salaries, administrative salaries,
56.9 other salaries, payroll taxes, and fringe benefits;

56.10 (2) general operating expenses, including supplies, training, repairs, purchased services
56.11 and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working
56.12 capital interest;

56.13 (3) property related costs, including depreciation, capital debt interest, rent, and leases;
56.14 and

56.15 (4) total annual resident days.

56.16 Subd. 2. **Labor market reporting.** All intermediate care facilities shall comply with
56.17 the labor market reporting requirements described in section 256B.4912, subdivision 1a.

ARTICLE 5:

224.9 Sec. 47. Minnesota Statutes 2018, section 256B.5015, subdivision 2, is amended to read:

224.10 Subd. 2. **Services during the day.** (a) Services during the day, as defined in section
224.11 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through
224.12 payment ~~no later than January 1, 2004~~. The commissioner shall establish rates for these
224.13 services, other than day training and habilitation services, at ~~levels that do not exceed 75~~
224.14 100 percent of a recipient's day training and habilitation service costs prior to the service
224.15 change.

224.16 (b) An individual qualifies for services during the day under paragraph (a) if:

224.17 (1) through consultation with the individual and their support team or interdisciplinary
224.18 team, it has been determined that the individual's needs can best be met through partial or
224.19 full retirement from:

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224.20 (i) participation in a day training and habilitation service; or

224.21 (ii) the use of services during the day in the individual's home environment; and

224.22 (2) in consultation with the individual and their support team or interdisciplinary team, an individualized plan has been developed with designated outcomes that:

224.24 (i) addresses the support needs and desires contained in the person-centered plan or individual support plan; and

224.26 (ii) includes goals that focus on community integration as appropriate for the individual.

224.27 (c) When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the ~~individualized service~~ individual support plan and the person's need for active treatment as defined under federal regulations. The pass-through payments for services during the day shall be paid separately by the commissioner and shall not be included in the computation of the ICF/DD facility total payment rate.

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300.12 Sec. 53. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

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

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

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

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

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

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

300.23 (1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

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

300.26 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

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225.3 Sec. 48. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

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

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

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

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

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

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

225.14 (1) based on an assessment under section 256B.0911, require assistance and be determined dependent in one critical activity of daily living or one Level I behavior ~~based on assessment under section 256B.0911~~ or have a behavior that shows increased vulnerability due to cognitive deficits or socially inappropriate behavior that requires assistance at least four times per week; and

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

225.20 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

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

301.1 Sec. 54. Minnesota Statutes 2018, section 256B.85, is amended by adding a subdivision
301.2 to read:

301.3 Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS
301.4 must be paid for services provided to persons who qualify for 12 or more hours of CFSS
301.5 per day when provided by a support worker who meets the requirements of subdivision 16,
301.6 paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate
301.7 adjustments implemented by the commissioner on July 1, 2019, to comply with the terms
301.8 of a collective bargaining agreement between the state of Minnesota and an exclusive
301.9 representative of individual providers under section 179A.54 that provides for wage increases
301.10 for individual providers who serve participants assessed to need 12 or more hours of CFSS
301.11 per day.

301.12 **EFFECTIVE DATE.** This section is effective July 1, 2019.

225.24 Sec. 49. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

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

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

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

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

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

226.9 (3) the presence of Level I behavior.

226.10 (d) The methodology to determine the total service units for CFSS for each home care
226.11 rating is based on the median paid units per day for each home care rating from fiscal year
226.12 2007 data for the PCA program.

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

226.15 (1) P LT home care rating requires Level I behavior or one to three dependencies in
226.16 ADLs and qualifies the person for five service units the presence of increased vulnerability
226.17 due to cognitive deficits and socially inappropriate behavior that requires assistance at least
226.18 four times per week, the presence of a Level I behavior, or a dependency in one critical
226.19 activity of daily living, and qualifies the person for two service units;

226.20 (2) P home care rating requires two to three dependencies in ADLs, one of which must
226.21 be a critical ADL, and qualifies the person for five services units;

226.22 (3) Q home care rating requires Level I behavior and one two to three dependencies in
226.23 ADLs, one of which must be a critical ADL, and qualifies the person for six service units;

226.24 (3) (4) R home care rating requires a complex health-related need and one two to three
226.25 dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for
226.26 seven service units;

226.27 (4) (5) S home care rating requires four to six dependencies in ADLs, one of which must
226.28 be a critical ADL, and qualifies the person for ten service units;

226.29 (5) (6) T home care rating requires Level I behavior and four to six dependencies in
226.30 ADLs and Level I behavior, one of which must be a critical ADL, and qualifies the person
226.31 for 11 service units;

227.1 (6) (7) U home care rating requires four to six dependencies in ADLs, one of which
227.2 must be a critical ADL, and a complex health-related need and qualifies the person for 14
227.3 service units;

227.4 (7) (8) V home care rating requires seven to eight dependencies in ADLs and qualifies
227.5 the person for 17 service units;

227.6 (8) (9) W home care rating requires seven to eight dependencies in ADLs and Level I
227.7 behavior and qualifies the person for 20 service units;

227.8 (9) (10) Z home care rating requires seven to eight dependencies in ADLs and a complex
227.9 health-related need and qualifies the person for 30 service units; and

227.10 (10) (11) EN home care rating includes ventilator dependency as defined in section
227.11 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of
227.12 ventilator-dependent and the EN home care rating and utilize a combination of CFSS and
227.13 home care nursing services is limited to a total of 96 service units per day for those services
227.14 in combination. Additional units may be authorized when a person's assessment indicates
227.15 a need for two staff to perform activities. Additional time is limited to 16 service units per
227.16 day.

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

227.19 (1) 30 additional minutes per day for a dependency in each critical activity of daily
227.20 living;

227.21 (2) 30 additional minutes per day for each complex health-related need; and

227.22 (3) 30 additional minutes per day when the behavior requires assistance at least four
227.23 times per week for one or more of the following behaviors:

227.24 (i) level I behavior;

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

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

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

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

227.31 (2) an adjustment needed for administrative expenses.

ARTICLE 1:

301.13 Sec. 55. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

301.14 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
301.15 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
301.16 13a shall:

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

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

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

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

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

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

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

56.18 Sec. 53. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

56.19 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
56.20 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
56.21 13a shall:

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

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

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

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

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

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

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

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

302.3 (9) have an office located in Minnesota.

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

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

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

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

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

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

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

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

302.17 (8) maintain documentation for the requirements under subdivision 16, paragraph (e),
302.18 clause (2), to qualify for an enhanced rate under this section.

302.19 **EFFECTIVE DATE.** This section is effective July 1, 2019.

302.20 Sec. 56. Minnesota Statutes 2018, section 256B.85, subdivision 11, is amended to read:

302.21 Subd. 11. **Agency-provider model.** (a) The agency-provider model includes services
302.22 provided by support workers and staff providing worker training and development services
302.23 who are employed by an agency-provider that meets the criteria established by the
302.24 commissioner, including required training.

302.25 (b) The agency-provider shall allow the participant to have a significant role in the
302.26 selection and dismissal of the support workers for the delivery of the services and supports
302.27 specified in the participant's CFSS service delivery plan.

302.28 (c) A participant may use authorized units of CFSS services as needed within a service
302.29 agreement that is not greater than 12 months. Using authorized units in a flexible manner
302.30 in either the agency-provider model or the budget model does not increase the total amount

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

57.11 (9) have an office located in Minnesota.

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

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

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

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

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

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

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

57.23 (7) comply with the labor market reporting requirements described in section 256B.4912,
57.24 subdivision 1a; and

57.25 (8) comply with any data requests from the department consistent with the Minnesota
57.26 Government Data Practices Act under chapter 13.

303.1 of services and supports authorized for a participant or included in the participant's CFSS
303.2 service delivery plan.

303.3 (d) A participant may share CFSS services. Two or three CFSS participants may share
303.4 services at the same time provided by the same support worker.

303.5 (e) The agency-provider must use a minimum of 72.5 percent of the revenue generated
303.6 by the medical assistance payment for CFSS for support worker wages and benefits, except
303.7 all of the revenue generated by a medical assistance rate increase due to a collective
303.8 bargaining agreement under section 179A.54 must be used for support worker wages and
303.9 benefits. The agency-provider must document how this requirement is being met. The
303.10 revenue generated by the worker training and development services and the reasonable costs
303.11 associated with the worker training and development services must not be used in making
303.12 this calculation.

303.13 (f) The agency-provider model must be used by individuals who are restricted by the
303.14 Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to
303.15 9505.2245.

303.16 (g) Participants purchasing goods under this model, along with support worker services,
303.17 must:

303.18 (1) specify the goods in the CFSS service delivery plan and detailed budget for
303.19 expenditures that must be approved by the consultation services provider, case manager, or
303.20 care coordinator; and

303.21 (2) use the FMS provider for the billing and payment of such goods.

303.22 Sec. 57. Minnesota Statutes 2018, section 256B.85, subdivision 12, is amended to read:

303.23 Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS
303.24 agency-providers must provide, at the time of enrollment, reenrollment, and revalidation
303.25 as a CFSS agency-provider in a format determined by the commissioner, information and
303.26 documentation that includes, but is not limited to, the following:

303.27 (1) the CFSS agency-provider's current contact information including address, telephone
303.28 number, and e-mail address;

303.29 (2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's
303.30 Medicaid revenue in the previous calendar year is less than or equal to $300,000, the
303.31 agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid
303.32 revenue in the previous calendar year is greater than $300,000, the agency-provider must
304.1 purchase a surety bond of $100,000. The surety bond must be in a form approved by the
304.2 commissioner, must be renewed annually, and must allow for recovery of costs and fees in
304.3 pursuing a claim on the bond;

304.4 (3) proof of fidelity bond coverage in the amount of $20,000;

304.5 (4) proof of workers' compensation insurance coverage;

304.6 (5) proof of liability insurance;

304.7 (6) a description of the CFSS agency-provider's organization identifying the names of
304.8 all owners, managing employees, staff, board of directors, and the affiliations of the directors
304.9 and owners to other service providers;

304.10 (7) a copy of the CFSS agency-provider's written policies and procedures including:
304.11 hiring of employees; training requirements; service delivery; and employee and consumer
304.12 safety, including the process for notification and resolution of participant grievances, incident
304.13 response, identification and prevention of communicable diseases, and employee misconduct;

304.14 (8) copies of all other forms the CFSS agency-provider uses in the course of daily
304.15 business including, but not limited to:

304.16 (i) a copy of the CFSS agency-provider's time sheet; and

304.17 (ii) a copy of the participant's individual CFSS service delivery plan;

304.18 (9) a list of all training and classes that the CFSS agency-provider requires of its staff
304.19 providing CFSS services;

304.20 (10) documentation that the CFSS agency-provider and staff have successfully completed
304.21 all the training required by this section;

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

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

304.25 (13) documentation that the agency-provider will use at least the following percentages
304.26 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
304.27 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
304.28 100 percent of the revenue generated by a medical assistance rate increase due to a collective
304.29 bargaining agreement under section 179A.54 must be used for support worker wages and
304.30 benefits. The revenue generated by the worker training and development services and the
304.31 reasonable costs associated with the worker training and development services shall not be
304.32 used in making this calculation; and

305.1 (14) documentation that the agency-provider does not burden participants' free exercise
305.2 of their right to choose service providers by requiring CFSS support workers to sign an
305.3 agreement not to work with any particular CFSS participant or for another CFSS
305.4 agency-provider after leaving the agency and that the agency is not taking action on any
305.5 such agreements or requirements regardless of the date signed.

305.6 (b) CFSS agency-providers shall provide to the commissioner the information specified
305.7 in paragraph (a).

305.8 (c) All CFSS agency-providers shall require all employees in management and
305.9 supervisory positions and owners of the agency who are active in the day-to-day management
305.10 and operations of the agency to complete mandatory training as determined by the
305.11 commissioner. Employees in management and supervisory positions and owners who are
305.12 active in the day-to-day operations of an agency who have completed the required training
305.13 as an employee with a CFSS agency-provider do not need to repeat the required training if
305.14 they are hired by another agency, if they have completed the training within the past three
305.15 years. CFSS agency-provider billing staff shall complete training about CFSS program
305.16 financial management. Any new owners or employees in management and supervisory
305.17 positions involved in the day-to-day operations are required to complete mandatory training
305.18 as a requisite of working for the agency.

305.19 (d) The commissioner shall send annual review notifications to agency-providers 30
305.20 days prior to renewal. The notification must:

305.21 (1) list the materials and information the agency-provider is required to submit;

305.22 (2) provide instructions on submitting information to the commissioner; and

305.23 (3) provide a due date by which the commissioner must receive the requested information.

305.24 Agency-providers shall submit all required documentation for annual review within 30 days
305.25 of notification from the commissioner. If an agency-provider fails to submit all the required
305.26 documentation, the commissioner may take action under subdivision 23a.

305.27 Sec. 58. Minnesota Statutes 2018, section 256B.85, subdivision 16, is amended to read:

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

305.29 (1) enroll with the department as a support worker after a background study under chapter
305.30 245C has been completed and the support worker has received a notice from the
305.31 commissioner that the support worker:

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

306.1 (ii) is disqualified, but has received a set-aside of the disqualification under section
306.2 245C.22;

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

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

306.7 (4) complete the basic standardized CFSS training as determined by the commissioner
306.8 before completing enrollment. The training must be available in languages other than English
306.9 and to those who need accommodations due to disabilities. CFSS support worker training
306.10 must include successful completion of the following training components: basic first aid,
306.11 vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and

306.12 responsibilities of support workers including information about basic body mechanics,
306.13 emergency preparedness, orientation to positive behavioral practices, orientation to
306.14 responding to a mental health crisis, fraud issues, time cards and documentation, and an
306.15 overview of person-centered planning and self-direction. Upon completion of the training
306.16 components, the support worker must pass the certification test to provide assistance to
306.17 participants;

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

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

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

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

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

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

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

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

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

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

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

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

307.12 (1) provides services, within the scope of CFSS described in subdivision 7, to a participant
307.13 who qualifies for 12 or more hours per day of CFSS; and

307.14 (2) satisfies the current requirements of Medicare for training and competency or
307.15 competency evaluation of home health aides or nursing assistants, as provided in the Code

307.16 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved
307.17 training or competency requirements.

307.18 **EFFECTIVE DATE.** This section is effective July 1, 2019.

ARTICLE 5:

228.1 Sec. 50. Minnesota Statutes 2018, section 256C.23, is amended by adding a subdivision
228.2 to read:

228.3 Subd. 7. **Family and community intervener.** "Family and community intervener"
228.4 means a paraprofessional, specifically trained in deafblindness, who works one-on-one with
228.5 a child who is deafblind to provide critical connections to people and the environment.

228.6 Sec. 51. Minnesota Statutes 2018, section 256C.261, is amended to read:
228.7 256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND.

228.8 (a) The commissioner of human services shall use at least 35 percent of the deafblind
228.9 services biennial base level grant funding for services and other supports for a child who is
228.10 deafblind and the child's family. The commissioner shall use at least 25 percent of the
228.11 deafblind services biennial base level grant funding for services and other supports for an
228.12 adult who is deafblind.

228.13 The commissioner shall award grants for the purposes of:

228.14 (1) providing services and supports to persons who are deafblind; and

228.15 (2) developing and providing training to counties and the network of senior citizen
228.16 service providers. The purpose of the training grants is to teach counties how to use existing
228.17 programs that capture federal financial participation to meet the needs of eligible persons
228.18 who are deafblind and to build capacity of senior service programs to meet the needs of
228.19 seniors with a dual sensory hearing and vision loss.

228.20 (b) The commissioner may make grants:

228.21 (1) for services and training provided by organizations; and

228.22 (2) to develop and administer consumer-directed services.

228.23 (c) Consumer-directed services shall be provided in whole by grant-funded providers.
228.24 The Deaf and Hard-of-Hearing Services Division's regional service centers shall not provide
228.25 any aspect of a grant-funded consumer-directed services program.

228.26 (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under
228.27 paragraph (a).

228.28 (e) Deafblind service providers may, but are not required to, provide intervenor services
228.29 as part of the service package provided with grant funds under this section. Intervener

228.30 services include services provided by a family and community intervener as described in
228.31 paragraph (f).

229.1 (f) The family and community intervener, as defined in section 256C.23, subdivision 7,
229.2 provides services to open channels of communication between the child and others; facilitate
229.3 the development or use of receptive and expressive communication skills by the child; and
229.4 develop and maintain a trusting, interactive relationship that promotes social and emotional
229.5 well-being. The family and community intervener also provides access to information and
229.6 the environment, and facilitates opportunities for learning and development. A family and
229.7 community intervener must have specific training in deafblindness, building language and
229.8 communication skills, and intervention strategies.

229.9 Sec. 52. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

229.10 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
229.11 services provided to individuals in addition to room and board including, but not limited
229.12 to, oversight and up to 24-hour supervision, medication reminders, assistance with
229.13 transportation, arranging for meetings and appointments, and arranging for medical and
229.14 social services, and services identified in section 256I.03, subdivision 12.

229.15 Sec. 53. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

229.16 Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers
229.17 of housing support must be in writing on a form developed and approved by the commissioner
229.18 and must specify the name and address under which the establishment subject to the
229.19 agreement does business and under which the establishment, or service provider, if different
229.20 from the group residential housing establishment, is licensed by the Department of Health
229.21 or the Department of Human Services; the specific license or registration from the
229.22 Department of Health or the Department of Human Services held by the provider and the
229.23 number of beds subject to that license; the address of the location or locations at which
229.24 group residential housing is provided under this agreement; the per diem and monthly rates
229.25 that are to be paid from housing support funds for each eligible resident at each location;
229.26 the number of beds at each location which are subject to the agreement; whether the license
229.27 holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code;
229.28 and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06
229.29 and subject to any changes to those sections.

229.30 (b) Providers are required to verify the following minimum requirements in the
229.31 agreement:

229.32 (1) current license or registration, including authorization if managing or monitoring
229.33 medications;

230.1 (2) all staff who have direct contact with recipients meet the staff qualifications;

230.2 (3) the provision of housing support;

230.3 (4) the provision of supplementary services, if applicable;

230.4 (5) reports of adverse events, including recipient death or serious injury; ~~and~~

230.5 (6) submission of residency requirements that could result in recipient eviction~~.~~; and

230.6 (7) confirmation that the provider will not limit or restrict the number of hours an
230.7 applicant or recipient chooses to be employed, as specified in subdivision 5.

230.8 (c) Agreements may be terminated with or without cause by the commissioner, the
230.9 agency, or the provider with two calendar months prior notice. The commissioner may
230.10 immediately terminate an agreement under subdivision 2d.

230.11 Sec. 54. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
230.12 to read:

230.13 Subd. 2h. **Required supplementary services.** Providers of supplementary services shall
230.14 ensure that recipients have, at a minimum, assistance with services as identified in the
230.15 recipient's professional statement of need under section 256I.03, subdivision 12. Providers
230.16 of supplementary services shall maintain case notes with the date and description of services
230.17 provided to individual recipients.

230.18 Sec. 55. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
230.19 to read:

230.20 Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number
230.21 of hours an applicant or recipient is employed.

230.22 Sec. 56. Minnesota Statutes 2018, section 256I.05, subdivision 1r, is amended to read:

230.23 Subd. 1r. **Supplemental rate; Anoka County.** (a) Notwithstanding the provisions in
230.24 this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to
230.25 the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
230.26 1a, including any legislatively authorized inflationary adjustments, for a housing support
230.27 provider that is located in Anoka County and provides emergency housing on the former
230.28 Anoka Regional Treatment Center campus.

230.29 (b) Notwithstanding the provisions in this section, a county agency shall negotiate a
230.30 supplemental rate for six beds in addition to the rate specified in subdivision 1, not to exceed
231.1 the maximum rate allowed under subdivision 1a, including any legislatively authorized
231.2 inflationary adjustments, for a housing support provider located in Anoka County that
231.3 operates a 12-bed facility and provides room and board and supplementary services to
231.4 individuals 18 to 24 years of age.

231.5 **EFFECTIVE DATE.** This section is effective July 1, 2019.

231.6 Sec. 57. [268A.061] HOME AND COMMUNITY-BASED PROVIDERS.

231.7 Subdivision 1. **Home and community-based provider eligibility for**
231.8 **payments.** Notwithstanding Minnesota Rules, part 3300.5060, subparts 14 to 16, the
231.9 commissioner shall make payments for job-related services, vocational adjustment training,

231.10 and vocational evaluation services to any home and community-based services provider
231.11 licensed as an intensive support services provider under chapter 245D with whom the
231.12 commissioner has signed a limited-use vendor operating agreement.

231.13 Subd. 2. **Limited-use agreements with home and community-based providers.** A
231.14 limited-use vendor operating agreement under this section may not limit the dollar amount
231.15 the provider may receive annually. The limited-use vendor operating agreement available
231.16 under this section must specify at a minimum that payments under the agreement are limited
231.17 to vocational rehabilitation services provided to individuals to whom the provider has
231.18 previously provided day services as described under section 245D.03, subdivision 1,
231.19 paragraph (c), clause (4), or any of the employment services described under section 245D.03,
231.20 subdivision 1, paragraph (c), clauses (5) to (7).

231.21 Subd. 3. **Required limited-use agreements.** The commissioner must enter into a
231.22 limited-use vendor operating agreement that meets at least the minimal requirements of
231.23 subdivision 2 with a provider eligible under subdivision 1 if:

231.24 (1) the home and community-based provider is not a current vocational rehabilitation
231.25 services provider;

231.26 (2) each individual to be served under the limited-use vendor operating agreement was
231.27 receiving day or employment services from the provider immediately prior to the provider
231.28 serving the individual under the terms of the agreement; and

231.29 (3) each individual to be served under the limited-use vendor operating agreement has
231.30 made an informed choice to remain with the provider.

232.1 Sec. 58. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to
232.2 read:
232.3 Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
232.4 **BUDGET METHODOLOGY EXCEPTION.**

232.5 (a) No later than September 30, 2017, if necessary, the commissioner of human services
232.6 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
232.7 and community-based services waivers authorized under Minnesota Statutes, sections
232.8 256B.092 and 256B.49, to expand the exception to the consumer-directed community
232.9 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide
232.10 up to 30 percent more funds for either:

232.11 (1) consumer-directed community supports participants who have a coordinated service
232.12 and support plan which identifies the need for an increased amount of services or supports
232.13 under consumer-directed community supports than the amount they are currently receiving
232.14 under the consumer-directed community supports budget methodology:

232.15 (i) to increase the amount of time a person works or otherwise improves employment
232.16 opportunities;

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232.17 (ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes,
232.18 section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or~~ paragraph (g), clause
232.19 (1), item (iii); or

232.20 (iii) to develop and implement a positive behavior support plan; or

232.21 (2) home and community-based waiver participants who are currently using licensed
232.22 providers for (i) employment supports or services during the day; or (ii) residential services,
232.23 either of which cost more annually than the person would spend under a consumer-directed
232.24 community supports plan for any or all of the supports needed to meet the goals identified
232.25 in paragraph (a), clause (1), items (i), (ii), and (iii).

232.26 (b) The exception under paragraph (a), clause (1), is limited to those persons who can
232.27 demonstrate that they will have to discontinue using consumer-directed community supports
232.28 and accept other non-self-directed waiver services because their supports needed for the
232.29 goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within
232.30 the consumer-directed community supports budget limits.

232.31 (c) The exception under paragraph (a), clause (2), is limited to those persons who can
232.32 demonstrate that, upon choosing to become a consumer-directed community supports
233.1 participant, the total cost of services, including the exception, will be less than the cost of
233.2 current waiver services.

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307.19 Sec. 59. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to
307.20 read:
307.21 Sec. 45. CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET
307.22 METHODOLOGY ~~EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND~~
307.23 ~~CRISIS RESIDENTIAL SETTINGS~~.

307.24 Subdivision 1. **Exception for persons leaving institutions and crisis residential**
307.25 **settings.** (a) By September 30, 2017, the commissioner shall establish an institutional and
307.26 crisis bed consumer-directed community supports budget exception process in the home
307.27 and community-based services waivers under Minnesota Statutes, sections 256B.092 and
307.28 256B.49. This budget exception process shall be available for any individual who:

307.29 (1) is not offered available and appropriate services within 60 days since approval for
307.30 discharge from the individual's current institutional setting; and

308.1 (2) requires services that are more expensive than appropriate services provided in a
308.2 noninstitutional setting using the consumer-directed community supports option.

308.3 (b) Institutional settings for purposes of this exception include intermediate care facilities
308.4 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
308.5 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
308.6 exception shall be limited to no more than the amount of appropriate services provided in
308.7 a noninstitutional setting as determined by the lead agency managing the individual's home

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233.3 Sec. 59. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to
233.4 read:
233.5 Sec. 45. CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET
233.6 METHODOLOGY ~~EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND~~
233.7 ~~CRISIS RESIDENTIAL SETTINGS~~.

233.8 Subdivision 1. **Exception for persons leaving institutions and crisis residential**
233.9 **settings.** (a) By September 30, 2017, the commissioner shall establish an institutional and
233.10 crisis bed consumer-directed community supports budget exception process in the home
233.11 and community-based services waivers under Minnesota Statutes, sections 256B.092 and
233.12 256B.49. This budget exception process shall be available for any individual who:

233.13 (1) is not offered available and appropriate services within 60 days since approval for
233.14 discharge from the individual's current institutional setting; and

233.15 (2) requires services that are more expensive than appropriate services provided in a
233.16 noninstitutional setting using the consumer-directed community supports option.

233.17 (b) Institutional settings for purposes of this exception include intermediate care facilities
233.18 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
233.19 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
233.20 exception shall be limited to no more than the amount of appropriate services provided in
233.21 a noninstitutional setting as determined by the lead agency managing the individual's home

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308.8	and community-based services waiver. The lead agency shall notify the Department of	233.22	and community-based services waiver. The lead agency shall notify the Department of
308.9	Human Services of the budget exception.	233.23	Human Services of the budget exception.
308.10	Subd. 2. **Shared services.** (a) Medical assistance payments for shared services under	233.24	Subd. 2. **Shared services.** (a) Medical assistance payments for shared services under
308.11	consumer-directed community supports are limited to this subdivision.	233.25	consumer-directed community supports are limited to this subdivision.
308.12	(b) For purposes of this subdivision, "shared services" means services provided at the	233.26	(b) For purposes of this subdivision, "shared services" means services provided at the
308.13	same time by the same direct care worker for individuals who have entered into an agreement	233.27	same time by the same direct care worker for individuals who have entered into an agreement
308.14	to share consumer-directed community support services.	233.28	to share consumer-directed community support services.
308.15	(c) Shared services may include services in the personal assistance category as outlined	233.29	(c) Shared services may include services in the personal assistance category as outlined
308.16	in the consumer-directed community supports community support plan and shared services	233.30	in the consumer-directed community supports community support plan and shared services
308.17	agreement, except:	233.31	agreement, except:
308.18	(1) services for more than three individuals provided by one worker at one time;	233.32	(1) services for more than three individuals provided by one worker at one time;
308.19	(2) use of more than one worker for the shared services; and	234.1	(2) use of more than one worker for the shared services; and
308.20	(3) a child care program licensed under chapter 245A or operated by a local school	234.2	(3) a child care program licensed under chapter 245A or operated by a local school
308.21	district or private school.	234.3	district or private school.
308.22	(d) The individuals or, as needed, their representatives shall develop the plan for shared	234.4	(d) The individuals or, as needed, their representatives shall develop the plan for shared
308.23	services when developing or amending the consumer-directed community supports plan,	234.5	services when developing or amending the consumer-directed community supports plan,
308.24	and must follow the consumer-directed community supports process for approval of the	234.6	and must follow the consumer-directed community supports process for approval of the
308.25	plan by the lead agency. The plan for shared services in an individual's consumer-directed	234.7	plan by the lead agency. The plan for shared services in an individual's consumer-directed
308.26	community supports plan shall include the intention to utilize shared services based on	234.8	community supports plan shall include the intention to utilize shared services based on
308.27	individuals' needs and preferences.	234.9	individuals' needs and preferences.
308.28	(e) Individuals sharing services must use the same financial management services	234.10	(e) Individuals sharing services must use the same financial management services
308.29	provider.	234.11	provider.
308.30	(f) Individuals whose consumer-directed community supports community support plans	234.12	(f) Individuals whose consumer-directed community supports community support plans
308.31	include the intention to utilize shared services must also jointly develop, with the support	234.13	include the intention to utilize shared services must also jointly develop, with the support
308.32	of their representatives as needed, a shared services agreement. This agreement must include:	234.14	of their representatives as needed, a shared services agreement. This agreement must include:
309.1	(1) the names of the individuals receiving shared services;	234.15	(1) the names of the individuals receiving shared services;
309.2	(2) the individuals' representative, if identified in their consumer-directed community	234.16	(2) the individuals' representative, if identified in their consumer-directed community
309.3	supports plans, and their duties;	234.17	supports plans, and their duties;
309.4	(3) the names of the case managers;	234.18	(3) the names of the case managers;
309.5	(4) the financial management services provider;	234.19	(4) the financial management services provider;
309.6	(5) the shared services that must be provided;	234.20	(5) the shared services that must be provided;
309.7	(6) the schedule for shared services;	234.21	(6) the schedule for shared services;
309.8	(7) the location where shared services must be provided;	234.22	(7) the location where shared services must be provided;

309.9 (8) the training specific to each individual served;

309.10 (9) the training specific to providing shared services to the individuals identified in the
309.11 agreement;

309.12 (10) instructions to follow all required documentation for time and services provided;

309.13 (11) a contingency plan for each of the individuals that accounts for service provision
309.14 and billing in the absence of one of the individuals in a shared services setting due to illness
309.15 or other circumstances;

309.16 (12) signatures of all parties involved in the shared services; and

309.17 (13) agreement by each of the individuals who are sharing services on the number of
309.18 shared hours for services provided.

309.19 (g) Any individual or any individual's representative may withdraw from participating
309.20 in a shared services agreement at any time.

309.21 (h) The lead agency for each individual must authorize the use of the shared services
309.22 option based on the criteria that the shared service is appropriate to meet the needs, health,
309.23 and safety of each individual for whom they provide case management or care coordination.

309.24 (i) Nothing in this subdivision must be construed to reduce the total authorized
309.25 consumer-directed community supports budget for an individual.

309.26 (j) No later than September 30, 2019, the commissioner of human services shall:

309.27 (1) submit an amendment to the Centers for Medicare and Medicaid Services for the
309.28 home and community-based services waivers authorized under Minnesota Statutes, sections
309.29 256B.092 and 256B.49, to allow for a shared services option under consumer-directed
309.30 community supports; and

310.1 (2) with stakeholder input, develop guidance for shared services in consumer-directed
310.2 community-supports within the Community Based Services Manual. Guidance must include:

310.3 (i) recommendations for negotiating payment for one-to-two and one-to-three services;
310.4 and

310.5 (ii) a template of the shared services agreement.

310.6 **EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval,
310.7 whichever is later, except for subdivision 2, paragraph (j), which is effective the day
310.8 following final enactment. The commissioner of human services shall notify the revisor of
310.9 statutes when federal approval is obtained.

310.10 Sec. 60. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
310.11 read:

234.23 (8) the training specific to each individual served;

234.24 (9) the training specific to providing shared services to the individuals identified in the
234.25 agreement;

234.26 (10) instructions to follow all required documentation for time and services provided;

234.27 (11) a contingency plan for each of the individuals that accounts for service provision
234.28 and billing in the absence of one of the individuals in a shared services setting due to illness
234.29 or other circumstances;

234.30 (12) signatures of all parties involved in the shared services; and

235.1 (13) agreement by each of the individuals who are sharing services on the number of
235.2 shared hours for services provided.

235.3 (g) Any individual or any individual's representative may withdraw from participating
235.4 in a shared services agreement at any time.

235.5 (h) The lead agency for each individual must authorize the use of the shared services
235.6 option based on the criteria that the shared service is appropriate to meet the needs, health,
235.7 and safety of each individual for whom they provide case management or care coordination.

235.8 (i) Nothing in this subdivision must be construed to reduce the total authorized
235.9 consumer-directed community supports budget for an individual.

235.10 (j) No later than September 30, 2019, the commissioner of human services shall:

235.11 (1) submit an amendment to the Centers for Medicare and Medicaid Services for the
235.12 home and community-based services waivers authorized under Minnesota Statutes, sections
235.13 256B.092 and 256B.49, to allow for a shared services option under consumer-directed
235.14 community supports; and

235.15 (2) with stakeholder input, develop guidance for shared services in consumer-directed
235.16 community-supports within the Community Based Services Manual. Guidance must include:

235.17 (i) recommendations for negotiating payment for one-to-two and one-to-three services;
235.18 and

235.19 (ii) a template of the shared services agreement.

235.20 **EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval,
235.21 whichever is later, except for subdivision 2, paragraph (j), which is effective the day
235.22 following final enactment. The commissioner of human services shall notify the revisor of
235.23 statutes when federal approval is obtained.

ARTICLE 1:

65.13 Sec. 65. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
65.14 read:

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310.12 Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~**
310.13 **VISIT VERIFICATION.**

310.14 Subdivision 1. **Documentation; establishment.** The commissioner of human services
310.15 shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery~~
310.16 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
310.17 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
310.18 with the electronic visit verification requirements in the 21st Century Cures Act, Public
310.19 Law 114-255.

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

310.22 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
310.23 documentation of the:

310.24 (1) type of service performed;

310.25 (2) individual receiving the service;

310.26 (3) date of the service;

310.27 (4) location of the service delivery;

310.28 (5) individual providing the service; and

310.29 (6) time the service begins and ends.

311.1 (c) "Electronic ~~service delivery documentation~~ visit verification system" means a system
311.2 that provides electronic ~~service delivery documentation~~ verification of services that complies
311.3 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
311.4 3.

311.5 (d) "Service" means one of the following:

311.6 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
311.7 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

311.8 (2) community first services and supports under Minnesota Statutes, section 256B.85;

311.9 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;
311.10 or

311.11 (4) other medical supplies and equipment or home and community-based services that
311.12 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

311.13 Subd. 3. **Requirements.** (a) In developing implementation requirements for ~~an~~ electronic
311.14 ~~service delivery documentation system~~ visit verification, the commissioner shall ~~consider~~
311.15 ~~electronic visit verification systems and other electronic service delivery documentation~~
311.16 ~~methods. The commissioner shall convene stakeholders that will be impacted by an electronic~~

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65.15 Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~**
65.16 **VISIT VERIFICATION.**

65.17 Subdivision 1. **Documentation; establishment.** The commissioner of human services
65.18 shall establish implementation requirements and standards for ~~an~~ electronic ~~service delivery~~
65.19 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
65.20 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
65.21 with the electronic visit verification requirements in the 21st Century Cures Act, Public
65.22 Law 114-255.

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

65.25 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
65.26 documentation of the:

65.27 (1) type of service performed;

65.28 (2) individual receiving the service;

65.29 (3) date of the service;

65.30 (4) location of the service delivery;

66.1 (5) individual providing the service; and

66.2 (6) time the service begins and ends.

66.3 (c) "Electronic ~~service delivery documentation~~ visit verification system" means a system
66.4 that provides electronic ~~service delivery documentation~~ verification of services that complies
66.5 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
66.6 3.

66.7 (d) "Service" means one of the following:

66.8 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
66.9 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

66.10 (2) community first services and supports under Minnesota Statutes, section 256B.85;

66.11 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;
66.12 or

66.13 (4) other medical supplies and equipment or home and community-based services that
66.14 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

66.15 Subd. 3. **System requirements.** (a) In developing implementation requirements for ~~an~~
66.16 electronic ~~service delivery documentation system~~ visit verification, the commissioner shall
66.17 ~~consider electronic visit verification systems and other electronic service delivery~~
66.18 ~~documentation methods. The commissioner shall convene stakeholders that will be impacted~~

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311.17 ~~service delivery system, including service providers and their representatives, service~~
311.18 ~~recipients and their representatives, and, as appropriate, those with expertise in the~~
311.19 ~~development and operation of an electronic service delivery documentation system, to~~ ensure
311.20 that the requirements:

311.21 (1) are minimally administratively and financially burdensome to a provider;

311.22 (2) are minimally burdensome to the service recipient and the least disruptive to the
311.23 service recipient in receiving and maintaining allowed services;

311.24 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
311.25 visit verification;

311.26 (4) are conducted according to all state and federal laws;

311.27 (5) are effective methods for preventing fraud when balanced against the requirements
311.28 of clauses (1) and (2); and

311.29 (6) are consistent with the Department of Human Services' policies related to covered
311.30 services, flexibility of service use, and quality assurance.

311.31 (b) The commissioner shall make training available to providers on the electronic ~~service~~
311.32 ~~delivery documentation~~ visit verification system requirements.

312.1 (c) The commissioner shall establish baseline measurements related to preventing fraud
312.2 and establish measures to determine the effect of electronic ~~service delivery documentation~~
312.3 visit verification requirements on program integrity.

312.4 (d) The commissioner shall make a state-selected electronic visit verification system
312.5 available to providers of services.

312.6 Subd. 3a. **Provider requirements.** (a) A provider of services may select any electronic
312.7 visit verification system that meets the requirements established by the commissioner.

312.8 (b) All electronic visit verification systems used by providers to comply with the
312.9 requirements established by the commissioner must provide data to the commissioner in a
312.10 format and at a frequency to be established by the commissioner.

312.11 (c) Providers must implement the electronic visit verification systems required under
312.12 this section by a date established by the commissioner to be set after the state-selected
312.13 electronic visit verification systems for personal care services and home health services are
312.14 in production. For purposes of this paragraph, "personal care services" and "home health
312.15 services" have the meanings given in United States Code, title 42, section 1396b(l)(5).
312.16 Reimbursement rates for providers must not be reduced as a result of federal action to reduce
312.17 the federal medical assistance percentage under the 21st Century Cures Act, Public Law
312.18 114-255.

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66.19 ~~by an electronic service delivery system, including service providers and their representatives,~~
66.20 ~~service recipients and their representatives, and, as appropriate, those with expertise in the~~
66.21 ~~development and operation of an electronic service delivery documentation system, to~~ ensure
66.22 that the requirements:

66.23 (1) are minimally administratively and financially burdensome to a provider;

66.24 (2) are minimally burdensome to the service recipient and the least disruptive to the
66.25 service recipient in receiving and maintaining allowed services;

66.26 (3) consider existing best practices and use of electronic ~~service delivery documentation~~
66.27 visit verification;

66.28 (4) are conducted according to all state and federal laws;

66.29 (5) are effective methods for preventing fraud when balanced against the requirements
66.30 of clauses (1) and (2); and

67.1 (6) are consistent with the Department of Human Services' policies related to covered
67.2 services, flexibility of service use, and quality assurance.

67.3 (b) The commissioner shall make training available to providers on the electronic ~~service~~
67.4 ~~delivery documentation~~ visit verification system requirements.

67.5 (c) The commissioner shall establish baseline measurements related to preventing fraud
67.6 and establish measures to determine the effect of electronic ~~service delivery documentation~~
67.7 visit verification requirements on program integrity.

67.8 (d) The commissioner shall make a state-selected electronic visit verification system
67.9 available to providers of services.

67.10 Subd. 3a. **Provider requirements.** (a) Providers of services may select their own
67.11 electronic visit verification system that meets the requirements established by the
67.12 commissioner.

67.13 (b) All electronic visit verification systems used by providers to comply with the
67.14 requirements established by the commissioner must provide data to the commissioner in a
67.15 format and at a frequency to be established by the commissioner.

67.16 (c) Providers must implement the electronic visit verification systems required under
67.17 this section by January 1, 2020, for personal care services and by January 1, 2023, for home
67.18 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
67.19 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
67.20 paragraph, "personal care services" and "home health services" have the meanings given
67.21 in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must
67.22 not be reduced as a result of federal action to reduce the federal medical assistance percentage

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312.19 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:

312.24 (1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and

312.26 (2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.

312.29 (b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.

313.1 Sec. 61. **INDIVIDUAL PROVIDERS OF DIRECT SUPPORT SERVICES.**

313.2 The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 11, 2019, is ratified.

313.5 **EFFECTIVE DATE.** This section is effective July 1, 2019.

313.6 Sec. 62. **RATE INCREASE FOR DIRECT SUPPORT SERVICES PROVIDERS WORKFORCE NEGOTIATIONS.**

313.8 (a) Effective July 1, 2019, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall:

313.12 (1) increase reimbursement rates, individual budgets, grants, or allocations by 2.37 percent for services provided on or after July 1, 2019, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

313.15 (2) for services provided on or after July 1, 2019, to eligible service recipients, provide an enhanced rate of 7.5 percent for personal care assistance and community first services and supports and an enhanced budget increased by 7.5 percent for consumer-directed community supports and the consumer support grant. Eligible service recipients are persons identified by the state through assessment who are eligible for at least 12 hours of personal care assistance each day and are served by workers who have completed designated training approved by the commissioner. The enhanced rate and enhanced budget includes, and is

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67.23 under the 21st Century Cures Act, Public Law 114.255, Code of Federal Regulations, title 32, section 310.32.

67.25 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:

67.30 (1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and

68.1 (2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.

68.4 (b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.

313.22 not in addition to, any previously implemented enhanced rates or enhanced budgets for
313.23 eligible service recipients.

313.24 (b) The rate changes described in this section apply to direct support services provided
313.25 through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision
313.26 1.

313.27 Sec. 63. **DIRECTION TO COMMISSIONER; SKILLED NURSE VISIT RATES.**

313.28 The commissioner of human services shall ensure that skilled nurse visits reimbursed
313.29 under Minnesota Statutes, section 256B.0653, are coded, specific to the category of the
313.30 nurse performing the visit, using code sets compliant with the Health Insurance Portability
313.31 and Accountability Act, Public Law 104-191. "Skilled nurse visit" has the meaning given
313.32 in Minnesota Statutes, section 256B.0653, subdivision 2, paragraph (j).

314.1 Sec. 64. **DIRECTION TO COMMISSIONER; INTERAGENCY AGREEMENTS.**

314.2 By October 1, 2019, the Department of Commerce, Public Utilities Commission, and
314.3 Department of Human Services must amend all interagency agreements necessary to
314.4 implement sections 1 to 10.

314.5 Sec. 65. **DIRECTION TO COMMISSIONER; FEDERAL AUTHORITY FOR**
314.6 **RECONFIGURED WAIVER SERVICES.**

314.7 The commissioner of human services shall seek necessary federal authority to implement
314.8 new and reconfigured waiver services under section 66. The commissioner of human services
314.9 shall notify the revisor of statutes when federal approval is obtained and when new services
314.10 are fully implemented.

314.11 Sec. 66. **DISABILITY WAIVER RECONFIGURATION.**

314.12 Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance
314.13 waiver programs for people with disabilities to simplify administration of the programs,
314.14 incentivize inclusive person-centered supports, enhance each person's personal authority
314.15 over the person's service choice, align benefits across waivers, encourage equity across
314.16 programs and populations, and promote long-term sustainability of needed services. To the
314.17 maximum extent possible, the disability waiver reconfiguration must maintain service
314.18 stability and continuity of care, while promoting the most independent and integrated
314.19 supports of each person's choosing in both short- and long-term planning.

314.20 Subd. 2. **Report.** By January 15, 2021, the commissioner of human services shall submit
314.21 a report to the members of the legislative committees with jurisdiction over human services
314.22 on any necessary waivers, state plan amendments, requests for new funding or realignment
314.23 of existing funds, any changes to state statute or rule, and any other federal authority
314.24 necessary to implement this section. The report must include information about the
314.25 commissioner's work to collect feedback and input from providers, persons accessing home
314.26 and community-based services waivers and their families, and client advocacy organizations.

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314.27 Subd. 3. **Proposal.** By January 15, 2021, the commissioner shall develop a proposal to
314.28 reconfigure the medical assistance waivers provided in sections 256B.092 and 256B.49.
314.29 The proposal shall include all necessary plans for implementing two home and
314.30 community-based services waiver programs, as authorized under section 1915(c) of the
314.31 Social Security Act that serve persons who are determined to require the levels of care
314.32 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
314.33 facility for persons with developmental disabilities. Before submitting the final report to
315.1 the legislature, the commissioner shall publish a draft report with sufficient time for interested
315.2 persons to offer additional feedback.

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

315.4 Sec. 67. **DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

315.5 The commissioner of human services, in consultation with stakeholders, shall evaluate
315.6 the feasibility of developing a rate methodology for the personal care assistance program,
315.7 under Minnesota Statutes, section 256B.0659, and community first services and supports,
315.8 under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system
315.9 under Minnesota Statutes, section 256B.4914, including determining the component values
315.10 and factors to include in such a rate methodology; consider aligning any rate methodology
315.11 with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,
315.12 section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct
315.13 care workers; develop methods and determine the necessary resources for the commissioner
315.14 to more consistently collect and audit data from the direct care industry; and report
315.15 recommendations, including proposed legislation, to the chairs and ranking minority members
315.16 of the legislative committees with jurisdiction over human services policy and finance by
315.17 February 1, 2020.

315.18 Sec. 68. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA**
315.19 **OPTION IMPROVEMENT MEASURES.**

315.20 (a) The commissioner of human services shall, using existing appropriations, develop
315.21 content to be included on the MNsure website explaining the TEFRA option under medical
315.22 assistance for applicants who indicate during the application process that a child in the
315.23 family has a disability.

315.24 (b) The commissioner shall develop a cover letter explaining the TEFRA option under
315.25 medical assistance, as well as the application and renewal process, to be disseminated with
315.26 the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA
315.27 option. The commissioner shall provide the content and the form to the executive director

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ARTICLE 5:

240.3 Sec. 70. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
240.4 **DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

240.5 The commissioner of human services, in consultation with stakeholders, shall evaluate
240.6 the feasibility of developing a rate methodology for the personal care assistance program
240.7 under Minnesota Statutes, section 256B.0659, and community first services and supports
240.8 under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system
240.9 under Minnesota Statutes, section 256B.4914, including determining the component values
240.10 and factors to include in such a rate methodology; consider aligning any rate methodology
240.11 with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,
240.12 section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct
240.13 care workers; develop methods and determine the necessary resources for the commissioner
240.14 to more consistently collect and audit data from the direct care industry; and report
240.15 recommendations, including proposed draft legislation, to the chairs and ranking minority
240.16 members of the legislative committees with jurisdiction over human services policy and
240.17 finance by February 1, 2020.

ARTICLE 2:

114.27 Sec. 40. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA**
114.28 **OPTION IMPROVEMENT MEASURES.**

114.29 (a) The commissioner of human services shall, using existing appropriations, develop
114.30 content to be included on the MNsure website explaining the TEFRA option under medical
114.31 assistance for applicants who indicate during the application process that a child in the
114.32 family has a disability.

115.1 (b) The commissioner shall develop a cover letter explaining the TEFRA option under
115.2 medical assistance, as well as the application and renewal process, to be disseminated with
115.3 the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA
115.4 option. The commissioner shall provide the content and the form to the executive director

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315.28 of MNsure for inclusion on the MNsure website. The commissioner shall also develop and
315.29 implement education and training for lead agency staff statewide to improve understanding
315.30 of the medical assistance TEFRA enrollment and renewal processes and procedures.

315.31 (c) The commissioner shall convene a stakeholder group that shall consider improvements
315.32 to the TEFRA option enrollment and renewal processes, including but not limited to revisions
316.1 to, or the development of, application and renewal paperwork specific to the TEFRA option;
316.2 possible technology solutions; and county processes.

316.3 (d) The stakeholder group must include representatives from the Department of Human
316.4 Services Health Care Division, MNsure, representatives from at least two counties in the
316.5 metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota,
316.6 Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance,
316.7 the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders
316.8 as identified by the commissioner of human services.

316.9 (e) The stakeholder group shall submit a report of the group's recommended
316.10 improvements and any associated costs to the commissioner by December 31, 2020. The
316.11 group shall also provide copies of the report to each stakeholder group member. The
316.12 commissioner shall provide a copy of the report to the legislative committees with jurisdiction
316.13 over medical assistance.

316.14 Sec. 69. **DIRECTION TO COMMISSIONER; DIRECT CARE STAFF**
316.15 **COMPENSATION REPORT.**

316.16 By January 15, 2022, the commissioner of human services, in consultation with
316.17 stakeholders, shall report to the chairs and ranking minority members of the legislative
316.18 committees and divisions with jurisdiction over health and human services policy and finance
316.19 with recommendations for:

316.20 (1) the implementation of penalties for providers who do not meet the compensation
316.21 levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a;

316.22 (2) the implementation of good cause exemptions for providers who have not met the
316.23 compensation levels identified in Minnesota Statutes, section 256B.4914, subdivision 5a;
316.24 and

316.25 (3) the rebasing of compensation levels identified in Minnesota Statutes, section
316.26 256B.4914, subdivision 5a, using data reported under Minnesota Statutes, section 256B.4914,
316.27 subdivision 10a.

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115.5 of MNsure for inclusion on the MNsure website. The commissioner shall also develop and
115.6 implement education and training for lead agency staff statewide to improve understanding
115.7 of the medical assistance-TEFRA enrollment and renewal processes and procedures.

115.8 (c) The commissioner shall convene a stakeholder group that shall consider improvements
115.9 to the TEFRA option enrollment and renewal processes, including but not limited to revisions
115.10 to, or the development of, application and renewal paperwork specific to the TEFRA option;
115.11 possible technology solutions; and county processes.

115.12 (d) The stakeholder group must include representatives from the Department of Human
115.13 Services Health Care Division, MNsure, representatives from at least two counties in the
115.14 metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota,
115.15 Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance,
115.16 the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders
115.17 as identified by the commissioner of human services.

115.18 (e) The stakeholder group shall submit a report of the group's recommended
115.19 improvements and any associated costs to the commissioner by December 31, 2020. The
115.20 group shall also provide copies of the report to each stakeholder group member. The
115.21 commissioner shall provide a copy of the report to the legislative committees with jurisdiction
115.22 over medical assistance.

ARTICLE 5:

235.24 Sec. 60. **DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE**
235.25 **SYSTEM TRANSITION GRANTS.**

235.26 (a) The commissioner of human services shall establish annual grants to day training
235.27 and habilitation providers that are projected to experience a funding gap upon the full
235.28 implementation of Minnesota Statutes, section 256B.4914.

235.29 (b) In order to be eligible for a grant under this section, a day training and habilitation
235.30 disability waiver provider must:

235.31 (1) serve at least 100 waiver service participants;

236.1 (2) be projected to receive a reduction in annual revenue from medical assistance for
236.2 day services during the first year of full implementation of disability waiver rate system
236.3 framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and
236.4 at least $300,000 compared to the annual medical assistance revenue for day services the
236.5 provider received during the last full year during which banded rates under Minnesota
236.6 Statutes, section 256B.4913, subdivision 4a, were effective; and

236.7 (3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

236.8 (c) A recipient of a grant under this section must develop a sustainability plan in
236.9 partnership with the commissioner of human services. The sustainability plan must include:

236.10 (1) a review of all the provider's costs and an assessment of whether the provider is
236.11 implementing available cost-control options appropriately;

236.12 (2) a review of all the provider's revenue and an assessment of whether the provider is
236.13 leveraging available resources appropriately; and

236.14 (3) a practical strategy for closing the funding gap described in paragraph (b), clause
236.15 (2).

236.16 (d) The commissioner of human services shall provide technical assistance and financial
236.17 management advice to grant recipients as they develop and implement their sustainability
236.18 plans.

236.19 (e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate
236.20 to the commissioner of human services that it made a good faith effort to close the revenue
236.21 gap described in paragraph (b), clause (2).

236.22 Sec. 61. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
236.23 **MNCHOICES 2.0.**

236.24 (a) The commissioner of human services must ensure that the MnCHOICES 2.0
236.25 assessment and support planning tool incorporates a qualitative approach with open-ended
236.26 questions and a conversational, culturally sensitive approach to interviewing that captures
236.27 the assessor's professional judgment based on the person's responses.

236.28 (b) If the commissioner of human services convenes a working group or consults with
236.29 stakeholders for the purposes of modifying the assessment and support planning process or

236.30 tool, the commissioner must include members of the disability community, including
236.31 representatives of organizations and individuals involved in assessment and support planning.

237.1 (c) Until MnCHOICES 2.0 is fully implemented, the commissioner shall permit counties
237.2 to use the most recent legacy documents related to long-term service and supports
237.3 assessments and shall reimburse counties in the same amount as the commissioner would
237.4 were the county using the MnCHOICES assessment tool.

237.5 Sec. 62. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
237.6 **PAYMENTS FOR COUNTY HUMAN SERVICES ACTIVITIES.**

237.7 By December 1, 2019, the commissioner of human services shall provide a report to the
237.8 chairs and ranking minority members of the legislative committees with jurisdiction over
237.9 human services finance and policy proposing a rate per assessment to be paid to counties
237.10 and tribes for all medical assistance and county human services activities currently reimbursed
237.11 via a random moment time study. The commissioner, in developing the proposal, shall use
237.12 past estimates of time spent on each relevant activity. The commissioner's report shall
237.13 include an explanation of how the commissioner determines the portion of capitated rates
237.14 paid to health plans attributable to each type of activity also performed by a county or tribe.
237.15 The commissioner's proposal must include a single rate per activity for each activity for all
237.16 populations, but may also include an alternative proposal for different rates per activity for
237.17 each activity for different populations.

237.18 Sec. 63. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
237.19 **BARRIERS TO INDEPENDENT LIVING.**

237.20 By December 1, 2019, the commissioner of human services shall submit to the chairs
237.21 and ranking minority members of the legislative committees with jurisdiction over human
237.22 services finance and policy a report describing state and federal regulatory barriers, including
237.23 provisions of the Fair Housing Act, that create barriers to independent living for persons
237.24 with disabilities. In developing the report, the commissioner shall consult with stakeholders,
237.25 including individuals with disabilities, advocacy organizations, and service providers.

237.26 Sec. 64. **ADULT FOSTER CARE MORATORIUM EXEMPTION.**

237.27 An adult foster care setting located in Elk River, Sherburne County, and licensed in
237.28 2003 to serve four people is exempt from the moratorium under Minnesota Statutes, section
237.29 245A.03, subdivision 7, until July 1, 2020.

237.30 **EFFECTIVE DATE.** This section is effective July 1, 2019.

238.1 Sec. 65. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
238.2 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
238.3 **COUNTY.**

238.4 (a) The commissioner of human services shall allow a housing with services establishment
238.5 located in Minneapolis that provides customized living and 24-hour customized living
238.6 services for clients enrolled in the brain injury (BI) or community access for disability

238.7 inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer
238.8 service capacity of up to 66 clients to no more than three new housing with services
238.9 establishments located in Hennepin County.

238.10 (b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall
238.11 determine that the new housing with services establishments described under paragraph (a)
238.12 meet the BI and CADI waiver customized living and 24-hour customized living size
238.13 limitation exception for clients receiving those services at the new housing with services
238.14 establishments described under paragraph (a).

238.15 Sec. 66. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
238.16 **PERSONAL CARE ASSISTANCE SERVICES COMPARABILITY WAIVER.**

238.17 The commissioner of human services shall submit by July 1, 2019, a waiver request to
238.18 the Centers for Medicare and Medicaid Services to allow people receiving personal care
238.19 assistance services as of December 31, 2019, to continue their eligibility for personal care
238.20 assistance services under the personal care assistance service eligibility criteria in effect on
238.21 December 31, 2019.

238.22 Sec. 67. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
238.23 **TRANSITION PERIOD FOR MODIFIED ELIGIBILITY OF PERSONAL CARE**
238.24 **ASSISTANCE.**

238.25 (a) Beginning at the latest date permissible under federal law, the modified eligibility
238.26 criteria under Minnesota Statutes, section 256B.0625, subdivision 19a, and Minnesota
238.27 Statutes, section 256B.0652, subdivision 6, paragraphs (b) and (d), shall apply on a rolling
238.28 basis, at the time of annual assessments, to people receiving personal care assistance as of
238.29 December 31, 2019.

238.30 (b) The commissioner shall establish a transition period for people receiving personal
238.31 care assistance services as of December 31, 2019, who, at the time of the annual assessment
238.32 described in paragraph (a), are determined to be ineligible for personal care assistance
238.33 services. Service authorizations for this transition period shall not exceed one year.

239.1 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
239.2 whichever is later. The commissioner shall notify the revisor of statutes when federal
239.3 approval is obtained and when personal care assistance services provided under paragraph
239.4 (b) have expired.

239.5 Sec. 68. **DIRECTION TO THE COMMISSIONER; REPORT ON ELIGIBILITY**
239.6 **FOR PERSONAL CARE ASSISTANCE AND ACCESS TO DEVELOPMENTAL**
239.7 **DISABILITIES AND COMMUNITY ACCESS FOR DISABILITY INCLUSION**
239.8 **WAIVERS.**

239.9 By December 15, 2020, the commissioner shall submit a report to chairs and ranking
239.10 minority members of the legislative committees with jurisdiction over human services on
239.11 modifications to the eligibility criteria for the personal care assistance program and limits

239.12 on the growth of the developmental disabilities and community access for disability inclusion
239.13 waivers enacted following the 2019 legislative session. The report shall include the impact
239.14 on people receiving or requesting services and any recommendations. By February 15, 2021,
239.15 the commissioner shall supplement the December 15, 2020, report with updated data and
239.16 information.

239.17 Sec. 69. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
239.18 **INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL**
239.19 **DISABILITIES LEVEL OF CARE CRITERIA.**

239.20 By February 1, 2020, the commissioner of human services shall submit to the chairs and
239.21 ranking minority members of the legislative committees with jurisdiction over health and
239.22 human services finance and policy recommended language to codify in Minnesota Statutes
239.23 the commissioner's existing criteria for the determination of need for intermediate care
239.24 facility for persons with developmental disabilities level of care. The recommended language
239.25 shall include language clarifying "at risk of placement," "reasonable indication," and "might
239.26 require" as those expressions are used in Minnesota Statutes, section 256B.092, subdivision
239.27 7, paragraph (b). The recommended statutory language shall also include the commissioner's
239.28 current guidance with respect to the interpretation and application of the federal standard
239.29 under Code of Federal Regulations, title 42, section 483.440, that a person receiving the
239.30 services of an intermediate care facility for persons with developmental disabilities require
239.31 a continuous active treatment plan, including which characteristics are necessary or sufficient
239.32 for a determination of a need for active treatment. The commissioner shall submit the
239.33 recommended statutory language with a letter listing, with statutory references, all the
240.1 programs and services for which an intermediate care facility for persons with developmental
240.2 disabilities level of care is required.

240.18 Sec. 71. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; HOME**
240.19 **CARE SERVICES PAYMENT REFORM PROPOSAL.**

240.20 The commissioner of human services shall submit to the chairs and ranking minority
240.21 members of the legislative committees with jurisdiction over human services finance and
240.22 policy a proposal to adopt a budget-neutral prospective payment system for nursing services
240.23 and home health services under Minnesota Statutes, sections 256B.0625, subdivision 6a,
240.24 and 256B.0653, and home care nursing services under Minnesota Statutes, sections
240.25 256B.0625, subdivision 7, and 256B.0624, modeled on the Medicare fee-for-service home
240.26 health prospective payment system. The commissioner shall include in the proposal a case
240.27 mix adjusted episodic rate, including services, therapies and supplies, minimum visits
240.28 required for an episodic rate, consolidated billing requirements, outlier payments,
240.29 low-utilization payments, and other criteria at the commissioner's discretion. In addition to
240.30 the budget-neutral payment reform proposal, the commissioner shall also submit a proposed
240.31 mechanism for updating the payment rates to reflect inflation in health care costs.

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241.1 Sec. 72. **DIRECTION TO THE COMMISSIONERS OF HUMAN SERVICES,**
241.2 **EDUCATION, AND EMPLOYMENT AND ECONOMIC DEVELOPMENT; PLAN**
241.3 **FOR SUPPORTED EMPLOYMENT.**

241.4 The commissioners of human services, education, and employment and economic
241.5 development, along with local education agencies, must assist persons with disabilities who
241.6 are between the ages of 14 and 24 to maximize their opportunities to achieve competitive
241.7 integrated employment through services provided by Vocational Rehabilitation Services
241.8 and local educational agencies and funded under Title I and Title VI, Part B of the
241.9 Rehabilitation Act. The agencies must have a coordinated plan to expand employment
241.10 options for participants with the most significant disabilities, including mental illness, for
241.11 whom competitive employment has not traditionally occurred or for whom competitive
241.12 employment has been interrupted or intermittent as a result of the severity of the individual's
241.13 disability, but who have:

241.14 (1) the ability or potential to engage in a training program leading to supported
241.15 employment;

241.16 (2) a need for intensive ongoing support services or extended services in order to perform
241.17 competitive work; and

241.18 (3) the ability to work in a supported employment setting.

241.19 This plan shall not include short-term job coaching and other related services for persons
241.20 who do not require supported employment services to enter or retain competitive
241.21 employment.

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316.28 Sec. 70. **REVISOR INSTRUCTION.**

316.29 The revisor of statutes, in consultation with the House Research Department, Office of
316.30 Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
316.31 prepare legislation for the 2020 legislative session to codify laws governing
316.32 consumer-directed community supports in Minnesota Statutes, chapter 256B.

317.1 Sec. 71. **REVISOR INSTRUCTION.**

317.2 The revisor of statutes shall renumber Minnesota Statutes, section 256B.4913, subdivision
317.3 5, as a subdivision in Minnesota Statutes, section 256B.4914. The revisor shall also make
317.4 necessary cross-reference changes in Minnesota Statutes consistent with the renumbering.

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241.22 Sec. 73. **REVISOR INSTRUCTION.**

241.23 (a) The revisor of statutes shall change the term "developmental disability waiver" or
241.24 similar terms to "developmental disabilities waiver" or similar terms wherever they appear
241.25 in Minnesota Statutes. The revisor shall also make technical and other necessary changes
241.26 to sentence structure to preserve the meaning of the text.

241.27 (b) The revisor of statutes, in consultation with the House Research Department, Office
241.28 of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
241.29 prepare legislation for the 2020 legislative session to codify existing session laws governing
241.30 consumer-directed community supports in Minnesota Statutes, chapter 256B.

ARTICLE 1:

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	69.6 Sec. 69. **REVISOR'S INSTRUCTION.**
	69.7 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article 69.8 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.
317.5 Sec. 72. **REPEALER.**	69.9 Sec. 70. **REPEALER.**
317.6 (a) Minnesota Statutes 2018, section 256B.0705, is repealed.	69.10 Minnesota Statutes 2018, section 256B.0705, is repealed.
317.7 (b) Minnesota Statutes 2018, sections 252.431; and 252.451, are repealed.	
317.8 (c) Minnesota Statutes 2018, sections 252.41, subdivision 8; and 256B.4913, subdivisions 317.9 4a, 6, and 7, are repealed.	
317.10 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment. 317.11 Paragraph (b) is effective September 1, 2019. Paragraph (c) is effective January 1, 2020.	69.11 **EFFECTIVE DATE.** This section is effective January 1, 2020.
	ARTICLE 5:
	241.31 Sec. 74. **REPEALER.**
	241.32 Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.