SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1127

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DATE	D-PG	OFFICIAL STATUS
02/10/2025	322	Introduction and first reading Referred to Human Services
02/20/2025	464	Author added Maye Quade See First Special Session, HF3

A bill for an act

relating to human services; modifying enhanced rates for community first services and supports; establishing professional competency and shift wage differential enhanced payment rates for community first services and supports; eliminating medical assistance asset limits for former recipients of medical assistance for employed persons with disabilities who are 65 and older; eliminating medical assistance premiums for employed persons with disabilities; providing for reimbursement of community first services and supports provided in acute care hospital settings; amending Minnesota Statutes 2024, sections 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.85, subdivisions 7a, 16; 256B.851, subdivisions 1, 3, 4, 5, 6.

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

Section 1. **CITATION.**

This act may be cited as the "Damon Leivestad Direct Care Sustainability Act."

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

Sec. 2. Minnesota Statutes 2024, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, spouses, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for

medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person age 64 years or younger who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability;

(6) ~~a designated employment incentives asset account is disregarded when determining eligibility for medical assistance~~ for a person age 65 years or older ~~under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded liquid assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9.~~ who no longer qualifies as an employed person with a disability due to loss of earnings and who had been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period immediately prior to an initial eligibility determination under section 256B.055, subdivision 7, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered at the time of an eligibility determination or at the time of a subsequent

eligibility redetermination. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under sections 256B.055, subdivision 15, and 256B.057, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who~~:~~

~~(1)~~ but for excess earnings or assets meets the definition of disabled under the Supplemental Security Income program~~; and~~.

~~(2) pays a premium and other obligations under paragraph (d).~~

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income, be receiving an unemployment insurance benefit under chapter 268 that the person began receiving while eligible under this subdivision, or be receiving family and medical leave benefits under chapter 268B that the person began receiving while eligible under this subdivision. A person who is self-employed must file and pay all applicable taxes. Any spousal income shall be disregarded for purposes of eligibility ~~and premium~~ determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who would otherwise be ineligible and be disenrolled due to one of the following circumstances may retain eligibility for up to four consecutive months after a month of job loss if the person:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income.

To receive a four-month extension of continued eligibility under this paragraph, enrollees must verify the medical condition or provide notification of job loss, and continue to meet all other eligibility requirements~~, and continue to pay all calculated premium costs~~.

~~(d) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).~~

~~(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.~~

~~(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.~~

~~(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).~~

~~(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.~~

~~(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.~~

~~(e)~~ (d) A person's eligibility ~~and premium~~ shall be determined by the local county agency. ~~Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.~~

~~(f) Any required premium shall be determined at application and redetermined at the enrollee's 12-month income review or when a change in income or household size is reported.~~ (e) Enrollees must report any change in income or household size within 30 days of when the change occurs. ~~A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next 12-month review.~~

~~(g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.~~

~~(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.~~

~~(i)~~ (f) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

~~(j)~~ (g) The commissioner is authorized to determine that a premium amount previously required under this subdivision was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error. The commissioner must permit any individual who was disenrolled for nonpayment of premiums previously required under this subdivision to reapply for medical assistance under this subdivision and, if eligible, to reenroll the individual without requiring the individual to pay past due premiums.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2024, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. **Enhanced ~~rate~~ rates.** (a) ~~An enhanced rate of 107.5 percent of the rate paid for CFSS~~ The following enhanced rate components must be ~~paid~~ applied for ~~services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the requirements of~~ CFSS that qualify for an enhanced rate under subdivision 16, paragraph (e)~~.~~:

(1) for CFSS provided to persons who qualify for ten to 14.9 hours of CFSS per day, 7.5 percent;

(2) for CFSS provided to persons who qualify for 15 to 19.9 hours of CFSS per day, 12.5 percent; and

(3) for CFSS provided to persons who qualify for 20 or more hours of CFSS per day, 17.5 percent.

(b) The following enhanced rate components must be applied:

(1) for CFSS provided to persons who qualify for any number of hours of CFSS per day when provided by an individual who is a licensed registered nurse, a licensed practical nurse, a certified home health aide, or a certified nursing assistant, 25 percent;

(2) for CFSS provided over a weekend to persons who qualify for any number of hours of CFSS per day when provided between the hours of 8 p.m. on a Friday and 8 a.m. the following Monday, ten percent; and

(3) for CFSS provided overnight to persons who qualify for any number of hours of CFSS per day when provided between 10 p.m. and 6 a.m., ten percent.

~~(b)~~ (c) An agency provider must use all additional revenue attributable to the rate enhancements under this subdivision for the wages and wage-related costs of the support workers, including any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums. The agency provider must not use the additional revenue attributable to any enhanced rate under this subdivision to pay for mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or any other employee benefits.

~~(c)~~ (d) Any change in the eligibility criteria for the enhanced rate for CFSS as described in this subdivision and referenced in subdivision 16, paragraph (e), does not constitute a change in a term or condition for individual providers as defined in section 256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter 179A.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2024, section 256B.85, subdivision 16, is amended to read:

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

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

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

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

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

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

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

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

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

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

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

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

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

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

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

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

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

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for ~~an~~ the enhanced ~~rate~~ rates described in subdivision 7a, paragraph (a), if the support worker providing the services:

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

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

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.851, subdivision 1, is amended to read:

Subdivision 1. **Application.** (a) The payment methodologies in this section apply to~~:~~

~~(1)~~ community first services and supports (CFSS), extended CFSS, and enhanced rate CFSS under section 256B.85~~; and~~, subdivision 7a.

~~(2) personal care assistance services under section 256B.0625, subdivisions 19a and 19c; extended personal care assistance services as defined in section 256B.0659, subdivision 1; and enhanced rate personal care assistance services under section 256B.0659, subdivision 17a.~~

(b) This section does not change existing ~~personal care assistance program or~~ community first services and supports policies and procedures.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2024, section 256B.851, subdivision 3, is amended to read:

Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage component values, the commissioner must use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the edition of the Occupational Handbook published in March 2021. The commissioner must calculate the base wage component values as follows ~~for~~:

(1) ~~personal care assistance services,~~ for CFSS~~, extended personal care assistance services,~~ and extended CFSS~~.~~, the base wage component value equals the median wage for personal care aide (SOC code 31-1120);

(2) ~~enhanced rate personal care assistance services and~~ for enhanced rate CFSS~~.~~, the base wage component value equals the product of median wage for personal care aide (SOC code 31-1120) and one plus the ~~value of the~~ sum of the applicable enhanced rate components under section ~~256B.0659, subdivision 17a~~ 256B.85, subdivision 7a; and

(3) for qualified professional services and CFSS worker training and development~~.~~, the base wage component value equals the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1099), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2024, section 256B.851, subdivision 4, is amended to read:

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

(b) For ~~personal care assistance services,~~ CFSS, ~~extended personal care assistance services,~~ extended CFSS, ~~enhanced rate personal care assistance services,~~ and enhanced rate CFSS, the initial competitive workforce factor is 4.7 percent.

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

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2024, section 256B.851, subdivision 5, is amended to read:

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

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

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

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

~~(b) For purposes of implementation, the commissioner shall use the following implementation components:~~

~~(1) personal care assistance services and CFSS: 88.19 percent;~~

~~(2) enhanced rate personal care assistance services and enhanced rate CFSS: 88.19 percent; and~~

~~(3) qualified professional services and CFSS worker training and development: 88.19 percent.~~

~~(c) Effective January 1, 2025,~~ (b) For purposes of implementation, the commissioner shall use the following implementation components:

(1) ~~personal care assistance services and~~ CFSS: 92.08 percent;

(2) ~~enhanced rate personal care assistance services and~~ enhanced rate CFSS: 92.08 percent; and

(3) qualified professional services and CFSS worker training and development: 92.08 percent.

~~(d)~~ (c) The commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 2.17 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.36 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 7.35 percent; and

(5) for workers who have provided more than 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 10.81 percent.

~~(e)~~ (d) The commissioner shall define the appropriate worker retention component based on the total number of units billed for services rendered by the individual provider since July 1, 2017. The worker retention component must be determined by the commissioner for each individual provider and is not subject to appeal.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2024, section 256B.851, subdivision 6, is amended to read:

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

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) In processing claims, the commissioner shall incorporate the worker retention component specified in subdivision 5, by multiplying one plus the total adjusted payment rate by the appropriate worker retention component under subdivision 5, paragraph (d).

(c) The commissioner must publish the total final payment rates.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. **COMMUNITY FIRST SERVICES AND SUPPORTS REIMBURSEMENT DURING ACUTE CARE HOSPITAL STAYS.**

(a) The commissioner of human services must seek to amend Minnesota's federally approved community first services and supports program, authorized under United States Code, title 42, sections 1915(i) and 1915(k), to reimburse for delivery of community first services and supports under Minnesota Statutes, sections 256B.85 and 256B.851, during an acute care stay in an acute care hospital setting that does not have the effect of isolating individuals receiving community first services and supports from the broader community

of individuals not receiving community first services and supports, as permitted under Code of Federal Regulations, title 42, section 441.530.

(b) Reimbursed services must:

(1) be identified in an individual's person-centered support plan as required under Minnesota Statutes, section 256B.0911;

(2) be provided to meet the needs of the person that are not met through the provision of hospital services;

(3) not substitute services that the hospital is obligated to provide as required under state and federal law; and

(4) be designed to preserve the person's functional abilities during a hospital stay for acute care and to ensure smooth transitions between acute care settings and home and community-based settings.

EFFECTIVE DATE. Paragraph (a) is effective the day following final enactment. Paragraph (b) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.