SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 3457

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DATE	D-PG	OFFICIAL STATUS
02/20/2020	4854	Introduction and first reading
		Referred to Human Services Reform Finance and Policy
03/04/2020		Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy

A bill for an act

relating to human services; establishing enrollment requirements for personal care assistance agencies; establishing additional duties for personal care assistants and qualified professionals; establishing a payment rate methodology for personal care assistance services; requiring commissioner of human services to study methodology; requiring providers to submit workforce data; requiring reports; amending Minnesota Statutes 2018, sections 256B.0625, by adding a subdivision; 256B.0659, subdivision 14, by adding a subdivision; 256B.69, subdivision 5a; Minnesota Statutes 2019 Supplement, sections 256B.0659, subdivisions 21, 24; 256B.85, subdivision 2; 256S.18, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

ARTICLE 1
PERSONAL CARE ASSISTANCE SERVICES PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 11a. **Personal care assistants; notice of change of employment required.** Within six months of ceasing employment as a personal care assistant with any personal care assistance provider agency, the personal care assistant must notify the commissioner on a form prescribed by the commissioner that the personal care assistant is no longer providing personal care assistance services on behalf of a personal care assistance provider agency with whom the personal care assistant was previously affiliated.

Sec. 2. Minnesota Statutes 2018, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) ~~Effective January 1, 2010,~~ All personal care assistants must be supervised by a qualified professional who is enrolled as an individual provider with the department as required under subdivision 13, paragraph (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) agency administrative activities;

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

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

(i) Within 30 days of ceasing employment as a qualified professional with any personal care assistance provider agency, the qualified professional must notify the commissioner on a form prescribed by the commissioner that the qualified professional is no longer providing qualified professional services on behalf of a personal care assistance provider agency with whom the qualified professional was previously affiliated.

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

Subd. 14a. **Documentation of qualified professional services provided.** Qualified professional services for a recipient must be documented in a manner determined by the commissioner and must include the qualified professional's full name and individual provider number.

Sec. 4. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 21, is amended to read:

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

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

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

(3) proof of fidelity bond coverage in the amount of $20,000 for each business location providing service;

(4) proof of workers' compensation insurance coverage identifying the business location where personal care assistance services are provided;

(5) proof of liability insurance coverage identifying the business location where personal care assistance services are provided and naming the department as a certificate holder;

(6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; identification, prevention, detection, and reporting of fraud or any billing, record keeping, or other administrative noncompliance; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(7) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(8) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(9) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced personal care assistance services are provided and submitted for an enhanced rate under subdivision 17a;

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

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

(12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal

care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; ~~and~~

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

(14) a copy of the personal care assistance provider agency's self-auditing policy and other materials demonstrating the personal care assistance provider agency's internal program integrity procedures;

(15) a copy of the personal care assistance provider agency's policy for notifying its qualified professionals of the qualified professional's obligation to notify the commissioner within 30 days that a qualified professional is no longer employed by the agency; and

(16) a copy of the personal care assistance provider agency's policy for notifying the commissioner within six months that a personal care assistant is no longer employed by the agency.

(b) All personal care assistance provider agencies must provide annually to the commissioner the information described in paragraph (a), clauses (2) to (5).

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

~~(c)~~ (d) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. The mandatory training, or any substantially similar refresher training developed by the commissioner, must be completed every two years thereafter. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who

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

~~(d)~~ (e) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

(f) Personal care assistance provider agencies enrolling for the first time must also provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation. The information and documentation must include proof of sufficient initial operating capital to support the infrastructure necessary to allow for ongoing compliance with the requirements of this section. Sufficient operating capital may be demonstrated as follows:

(1) copies of business bank account statements showing at least $5,000 in cash reserves;

(2) proof of a cash reserve or business line of credit sufficient to equal two payrolls of the agency's current or projected business; or

(3) any other manner prescribed by the commissioner.

(g) At the time of revalidation as a personal care assistance provider agency, all personal care assistance provider agencies must provide information and documentation in a format determined by the commissioner that includes but is not limited to the following:

(1) documentation of the payroll paid for the preceding 12 months or other time period as prescribed by the commissioner; and

(2) financial statements demonstrating compliance with the use of revenue requirements of paragraph (a), clause (12).

Sec. 5. Minnesota Statutes 2019 Supplement, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

(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;

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

(16) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the ~~PCAs~~ personal care assistants whose services meet the requirements under subdivision 11, paragraph (d)~~.~~;

(17) notify the commissioner on a form prescribed by the commissioner within 30 days following the date upon which a qualified professional is no longer employed by or otherwise affiliated with the personal care assistance provider agency for whom the qualified professional previously provided qualified professional services; and

(18) notify the commissioner on a form prescribed by the commissioner within six months following the date upon which a personal care assistant is no longer employed by or otherwise affiliated with the personal care assistance provider agency for whom the personal care assistant previously provided personal care assistance services.

ARTICLE 2
PERSONAL CARE ASSISTANT RATE REFORM

Section 1. Minnesota Statutes 2018, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

(2) by January 30 of each year in which a rate increase occurs for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract.

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

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

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

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

in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

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

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

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and

28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

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

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

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

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

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

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph.

Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Sec. 2. Minnesota Statutes 2019 Supplement, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

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

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

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

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in section 256S.10.

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

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

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

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

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

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

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

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

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

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

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

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

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

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

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

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and

must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

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

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

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

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

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

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

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

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

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

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance,

long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

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

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

Sec. 3. **[256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT RATES.**

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

(2) personal care assistance services under section 256B.0625, subdivisions 19a and 19c; extended personal care assistance service 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.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given in section 256B.85, subdivision 2, and as follows.

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

(c) "Component value" means an underlying factor that is built into the rate methodology to calculate service rates and is part of the cost of providing services.

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

Subd. 3. **Payment rates; base wage index.** 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 most recent edition of the Occupational Handbook. The commissioner must calculate the base wage component values for staff providing personal care assistance services, community first services and supports, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, and enhanced rate CFSS. The base wage component value must be the median wage for personal care aide (SOC code 39-9021).

Subd. 4. **Payment rates; base wage index adjustments.** (a) On July 1, 2022, and every two years thereafter, the commissioner must update the base wage component values based on the wage data by SOC codes from the Bureau of Labor Statistics available one year and a day prior to the scheduled update.

(b) The commissioner must publish the updated base wage component values.

Subd. 5. **Payment rates; total wage index.** (a) The commissioner must multiply the base wage component values by one plus the appropriate competitive workforce factor. The product is the total wage component value.

(b) For personal care assistance services, community first services and supports, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, and enhanced rate CFSS, the initial competitive workforce factor is .....

Subd. 6. **Payment rates; total wage index adjustments.** (a) On July 1, 2022, and every two years thereafter, the commissioner must adjust the competitive workforce factor in subdivision 5, paragraph (b), with an updated competitive workforce factor using the most recently available data. The commissioner must calculate the biennial adjustment to the competitive workforce factor as follows:

(1) subtract the weighted average for personal care aide (SOC code 39-9021) from the weighted average wage for all other SOC codes with the same Bureau of Labor Statistics classifications as personal care aide (SOC code 39-9021), for education, experience, and training for job competency;

(2) determine the average of (i) the weighted average for personal care aide (SOC code 39-9021) and (ii) the weighted average wage for all other SOC codes with the same Bureau of Labor Statistics classifications for education, experience, and training for job competency as for personal care aide (SOC code 39-9021);

(3) divide the result of clause (1) by the result of clause (2);

(4) if the result of clause (3) is positive, increase the competitive workforce factor by the lesser of the result of clause (3) and 0.01; and

(5) if the result of clause (3) is zero or negative, set the competitive workforce factor equal to zero.

(b) The commissioner must publish the updated competitive workforce value.

Subd. 7. **Payment rates; standard component values.** The commissioner must use the following standard component values:

(1) for the employee vacation, sick, and training factor, ... percent;

(2) for the employer taxes and workers' compensation factor, ... percent;

(3) for the employee benefits factor, ... percent;

(4) for the client programming and supports factor, ... percent;

(5) for the program plan support factor, ... percent;

(6) for the general business and administrative expenses factor, ... percent;

(7) for the program administration expenses factor, ... percent; and

(8) for the absence and utilization factor, ... percent.

Subd. 8. **Payment rates; rate determination.** (a) The commissioner must determine the rate for each service under subdivision 1 as follows:

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

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

(3) for employee-related expenses, add the employer taxes and workers' compensation factor and the employee benefits factor. 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;

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

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

(7) divide the hourly rate by four. The quotient is the total payment rate; and

(8) for enhanced rate personal care assistance services and enhanced rate CFSS, multiply the result of clause (7) by 1.075. The product is the enhanced total payment rate.

(b) The commissioner must publish the total payment rate and the enhanced total payment rate.

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

Subd. 10. **Required reporting of cost data.** (a) As determined by the commissioner and in consultation with stakeholders, agencies enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner. The commissioner may request cost data, including but not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; and

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

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

providers that have not provided required cost data 30 days after the required submission date and a second notice for providers who have not provided required cost data 60 days after the required submission date. The commissioner must temporarily suspend payments to a provider if the commissioner has not received required cost data 90 days after the required submission date. The commissioner must make withheld payments when the required cost data is received by the commissioner.

(c) The commissioner must conduct a random validation of data submitted under this subdivision to ensure data accuracy.

(d) The commissioner, in consultation with stakeholders, must develop and implement a process for providing training and technical assistance necessary to support provider submission of cost data required under this subdivision.

Subd. 11. **Required analysis of cost data.** (a) The commissioner must evaluate on an ongoing basis whether the base wage component values and standard component values in this section appropriately address costs to provide the services covered under this section. The commissioner must analyze cost data submitted under this section and may submit recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services on adjustments and updates to standard component values, base wage component values, and competitive workforce factors.

(b) The commissioner must release cost data in an aggregate form. Cost data from individual providers must not be released except as provided for in current law.

Subd. 12. **Payment rates; reports required.** (a) Notwithstanding subdivision 11, paragraph (a), the commissioner must assess the standard component values and publish evaluation findings and recommended changes to the rate methodology in a report to the legislature by August 1, 2023.

(b) The commissioner must assess the long-term impacts of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention. Notwithstanding subdivision 11, paragraph (a), the commissioner must publish evaluation findings in a report to the legislature by August 1, 2026.

(c) This subdivision expires on August 1, 2026, or upon the date the commissioner submits to the legislature the report described in paragraph (b), whichever is later. The commissioner must inform the revisor of statutes when the report is submitted.

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

Sec. 4. Minnesota Statutes 2019 Supplement, section 256S.18, subdivision 7, is amended to read:

Subd. 7. **Monthly case mix budget cap exception.** The commissioner ~~shall~~ must approve an exception to the monthly case mix budget cap in ~~paragraph (a)~~ subdivision 3 to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or enhanced rate community first services and supports under section 256B.85. ~~The exception shall not exceed 107.5 percent of the budget otherwise available to the individual.~~ The commissioner must calculate the difference between the rate for personal care assistance services and enhanced rate personal care assistance services. The additional budget amount approved under an exception must not exceed this difference. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

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