

ARTICLE 14

DISABILITY SERVICES AND CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2020, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health federal database MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Facility Resident Assessment Instrument User's Manual, version 3.0, and subsequent updates when or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments required under the Omnibus Budget Reconciliation Act of 1987 (OBRA) used to determine a case mix classification for reimbursement include the following:

(1) a new admission comprehensive assessment, which must have an assessment reference date (ARD) within 14 calendar days after admission, excluding readmissions;

(2) an annual comprehensive assessment, which must have an assessment reference date (ARD) ARD within 92 days of the a previous quarterly review assessment and the or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must be completed have an ARD within 14 days of the identification of after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement or a decline, and regardless of the amount of time since the last significant change in status comprehensive assessment or quarterly review assessment;

(4) all a quarterly assessments review assessment must have an assessment reference date (ARD) ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for RUG classification;

(7) a required significant change in status assessment when:

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Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification;

(c) In addition to the assessments listed in paragraph (b), a significant change in status assessment is required when:

513.13 (i) all speech, occupational, and physical therapies have ended. The ARD of this
513.14 assessment must be set on day eight after all therapy services have ended; and

513.15 (ii) isolation for an infectious disease has ended. The ARD of this assessment must be
513.16 set on day 15 after isolation has ended; and

513.17 (8) any modifications to the most recent assessments under clauses (1) to (7).

513.18 (c) In addition to the assessments listed in paragraph (b), the assessments used to
513.19 determine nursing facility level of care include the following:

513.20 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
513.21 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
513.22 Aging; and

513.23 (2) a nursing facility level of care determination as provided for under section 256B.0911,
513.24 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
513.25 under section 256B.0911, by a county, tribe, or managed care organization under contract
513.26 with the Department of Human Services.

432.7 (1) all speech, occupational, and physical therapies have ended. The assessment reference
432.8 date of this assessment must be set on day eight after all therapy services have ended; and

432.9 (2) isolation for an active infectious disease has ended. The assessment reference date
432.10 of this assessment must be set on day 15 after isolation has ended.

432.11 (d) In addition to the assessments listed in paragraph paragraphs (b) and (c), the
432.12 assessments used to determine nursing facility level of care include the following:

432.13 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
432.14 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
432.15 Aging; and

432.16 (2) a nursing facility level of care determination as provided for under section 256B.0911,
432.17 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
432.18 under section 256B.0911, by a county, tribe, or managed care organization under contract
432.19 with the Department of Human Services.

432.20 **EFFECTIVE DATE.** This section is effective for all assessments with an assessment
432.21 reference date of July 1, 2021, or later.

432.22 Sec. 2. Minnesota Statutes 2020, section 144A.073, subdivision 2, is amended to read:

432.23 Subd. 2. **Request for proposals.** At the authorization by the legislature of additional
432.24 medical assistance expenditures for exceptions to the moratorium on nursing homes, the
432.25 commissioner shall publish in the State Register a request for proposals for nursing home
432.26 and certified boarding care home projects for conversion, relocation, renovation, replacement,
432.27 upgrading, or addition. The public notice of this funding and the request for proposals must
432.28 specify how the approval criteria will be prioritized by the commissioner. The notice must
432.29 describe the information that must accompany a request and state that proposals must be
432.30 submitted to the commissioner within 150 days of the date of publication. The notice must
432.31 include the amount of the legislative appropriation available for the additional costs to the
432.32 medical assistance program of projects approved under this section. If money is appropriated,
433.1 the commissioner shall initiate the application and review process described in this section
433.2 at least once each biennium. A second application and review process must occur if remaining
433.3 funds are either greater than \$300,000 or more than 50 percent of the baseline appropriation
433.4 for the biennium. Authorized funds may be awarded in full in the first review process of
433.5 the biennium. Appropriated funds not encumbered within a biennium shall carry forward
433.6 to the following biennium. To be considered for approval, a proposal must include the
433.7 following information:

433.8 (1) whether the request is for renovation, replacement, upgrading, conversion, addition,
433.9 or relocation;

433.10 (2) a description of the problems the project is designed to address;

- 433.11 (3) a description of the proposed project;
- 433.12 (4) an analysis of projected costs of the nursing facility proposed project, including:
- 433.13 (i) initial construction and remodeling costs;
- 433.14 (ii) site preparation costs;
- 433.15 (iii) equipment and technology costs;
- 433.16 (iv) financing costs, the current estimated long-term financing costs of the proposal,
- 433.17 which is to include details of any proposed funding mechanism already arranged or being
- 433.18 considered, including estimates of the amount and sources of money, reserves if required,
- 433.19 annual payments schedule, interest rates, length of term, closing costs and fees, insurance
- 433.20 costs, any completed marketing study or underwriting review; and
- 433.21 (v) estimated operating costs during the first two years after completion of the project;
- 433.22 (5) for proposals involving replacement of all or part of a facility, the proposed location
- 433.23 of the replacement facility and an estimate of the cost of addressing the problem through
- 433.24 renovation;
- 433.25 (6) for proposals involving renovation, an estimate of the cost of addressing the problem
- 433.26 through replacement;
- 433.27 (7) the proposed timetable for commencing construction and completing the project;
- 433.28 (8) a statement of any licensure or certification issues, such as certification survey
- 433.29 deficiencies;
- 433.30 (9) the proposed relocation plan for current residents if beds are to be closed according
- 433.31 to section 144A.161; and
- 434.1 (10) other information required by permanent rule of the commissioner of health in
- 434.2 accordance with subdivisions 4 and 8.
- 434.3 Sec. 3. Minnesota Statutes 2020, section 144A.073, is amended by adding a subdivision
- 434.4 to read:
- 434.5 Subd. 17. **Moratorium exception funding.** (a) During the biennium beginning July 1,
- 434.6 2021, and during each biennium thereafter, the commissioner of health may approve
- 434.7 moratorium exception projects under this section for which the full biennial state share of
- 434.8 medical assistance costs does not exceed \$10,000,000, plus any carryover of previous
- 434.9 appropriations for this purpose.
- 434.10 (b) For the purposes of this subdivision, "biennium" has the meaning given in section
- 434.11 16A.011, subdivision 6.

513.27 Sec. 2. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

513.28 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
513.29 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
513.30 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
513.31 for a physical location that will not be the primary residence of the license holder for the
513.32 entire period of licensure. If a license is issued during this moratorium, and the license
514.1 holder changes the license holder's primary residence away from the physical location of
514.2 the foster care license, the commissioner shall revoke the license according to section
514.3 245A.07. The commissioner shall not issue an initial license for a community residential
514.4 setting licensed under chapter 245D. When approving an exception under this paragraph,
514.5 the commissioner shall consider the resource need determination process in paragraph (h),
514.6 the availability of foster care licensed beds in the geographic area in which the licensee
514.7 seeks to operate, the results of a person's choices during their annual assessment and service
514.8 plan review, and the recommendation of the local county board. The determination by the
514.9 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

514.15 (3) new foster care licenses or community residential setting licenses determined to be
514.16 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
514.17 or regional treatment center; restructuring of state-operated services that limits the capacity
514.18 of state-operated facilities; or allowing movement to the community for people who no
514.19 longer require the level of care provided in state-operated facilities as provided under section
514.20 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

514.24 (5) new foster care licenses or community residential setting licenses for people receiving
514.25 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
514.26 for which a license is required. This exception does not apply to people living in their own
514.27 home. For purposes of this clause, there is a presumption that a foster care or community
514.28 residential setting license is required for services provided to three or more people in a
514.29 dwelling unit when the setting is controlled by the provider. A license holder subject to this
514.30 exception may rebut the presumption that a license is required by seeking a reconsideration
514.31 of the commissioner's determination. The commissioner's disposition of a request for
514.32 reconsideration is final and not subject to appeal under chapter 14. The exception is available
514.33 until June 30, 2018. This exception is available when:

434.12 Sec. 4. Minnesota Statutes 2020, section 245A.03, subdivision 7, is amended to read:

434.13 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
434.14 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
434.15 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
434.16 for a physical location that will not be the primary residence of the license holder for the
434.17 entire period of licensure. If a license is issued during this moratorium, and the license
434.18 holder changes the license holder's primary residence away from the physical location of
434.19 the foster care license, the commissioner shall revoke the license according to section
434.20 245A.07. The commissioner shall not issue an initial license for a community residential
434.21 setting licensed under chapter 245D. When approving an exception under this paragraph,
434.22 the commissioner shall consider the resource need determination process in paragraph (h),
434.23 the availability of foster care licensed beds in the geographic area in which the licensee
434.24 seeks to operate, the results of a person's choices during their annual assessment and service
434.25 plan review, and the recommendation of the local county board. The determination by the
434.26 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

435.1 (3) new foster care licenses or community residential setting licenses determined to be
435.2 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
435.3 or regional treatment center; restructuring of state-operated services that limits the capacity
435.4 of state-operated facilities; or allowing movement to the community for people who no
435.5 longer require the level of care provided in state-operated facilities as provided under section
435.6 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

435.10 (5) new foster care licenses or community residential setting licenses for people receiving
435.11 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
435.12 for which a license is required. This exception does not apply to people living in their own
435.13 home. For purposes of this clause, there is a presumption that a foster care or community
435.14 residential setting license is required for services provided to three or more people in a
435.15 dwelling unit when the setting is controlled by the provider. A license holder subject to this
435.16 exception may rebut the presumption that a license is required by seeking a reconsideration
435.17 of the commissioner's determination. The commissioner's disposition of a request for
435.18 reconsideration is final and not subject to appeal under chapter 14. The exception is available
435.19 until June 30, 2018. This exception is available when:

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

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

515.7 (6) new foster care licenses or community residential setting licenses for people receiving
515.8 customized living or 24-hour customized living services under the brain injury or community
515.9 access for disability inclusion waiver plans under section 256B.49 and residing in the
515.10 customized living setting before July 1, 2022, for which a license is required. A customized
515.11 living service provider subject to this exception may rebut the presumption that a license
515.12 is required by seeking a reconsideration of the commissioner's determination. The
515.13 commissioner's disposition of a request for reconsideration is final and not subject to appeal
515.14 under chapter 14. The exception is available until June 30, 2023. This exception is available
515.15 when:

515.16 (i) the person's customized living services are provided in a customized living service
515.17 setting serving four or fewer people under the brain injury or community access for disability
515.18 inclusion waiver plans under section 256B.49 in a single-family home operational on or
515.19 before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

515.20 (ii) the person's case manager provided the person with information about the choice of
515.21 service, service provider, and location of service, including in the person's home, to help
515.22 the person make an informed choice; and

515.23 (iii) the person's services provided in the licensed foster care or community residential
515.24 setting are less than or equal to the cost of the person's services delivered in the customized
515.25 living setting as determined by the lead agency.

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

515.32 (c) When an adult resident served by the program moves out of a foster home that is not
515.33 the primary residence of the license holder according to section 256B.49, subdivision 15,
515.34 paragraph (f), or the adult community residential setting, the county shall immediately
516.1 inform the Department of Human Services Licensing Division. The department may decrease
516.2 the statewide licensed capacity for adult foster care settings.

516.3 (d) Residential settings that would otherwise be subject to the decreased license capacity
516.4 established in paragraph (c) shall be exempt if the license holder's beds are occupied by

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

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

435.26 (6) new foster care licenses or community residential setting licenses for people receiving
435.27 customized living or 24-hour customized living services under the brain injury or community
435.28 access for disability inclusion waiver plans under section 256B.49 and residing in the
435.29 customized living setting before July 1, 2022, for which a license is required. A customized
435.30 living service provider subject to this exception may rebut the presumption that a license
435.31 is required by seeking a reconsideration of the commissioner's determination. The
435.32 commissioner's disposition of a request for reconsideration is final and not subject to appeal
435.33 under chapter 14. The exception is available until June 30, 2023. This exception is available
435.34 when:

436.1 (i) the person's customized living services are provided in a customized living service
436.2 setting serving four or fewer people under the brain injury or community access for disability
436.3 inclusion waiver plans under section 256B.49 in a single-family home operational on or
436.4 before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

436.5 (ii) the person's case manager provided the person with information about the choice of
436.6 service, service provider, and location of service, including in the person's home, to help
436.7 the person make an informed choice; and

436.8 (iii) the person's services provided in the licensed foster care or community residential
436.9 setting are less than or equal to the cost of the person's services delivered in the customized
436.10 living setting as determined by the lead agency.

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

436.17 (c) When an adult resident served by the program moves out of a foster home that is not
436.18 the primary residence of the license holder according to section 256B.49, subdivision 15,
436.19 paragraph (f), or the adult community residential setting, the county shall immediately
436.20 inform the Department of Human Services Licensing Division. The department may decrease
436.21 the statewide licensed capacity for adult foster care settings.

436.22 (d) Residential settings that would otherwise be subject to the decreased license capacity
436.23 established in paragraph (c) shall be exempt if the license holder's beds are occupied by

516.5 residents whose primary diagnosis is mental illness and the license holder is certified under
516.6 the requirements in subdivision 6a or section 245D.33.

516.7 (e) A resource need determination process, managed at the state level, using the available
516.8 reports required by section 144A.351, and other data and information shall be used to
516.9 determine where the reduced capacity determined under section 256B.493 will be
516.10 implemented. The commissioner shall consult with the stakeholders described in section
516.11 144A.351, and employ a variety of methods to improve the state's capacity to meet the
516.12 informed decisions of those people who want to move out of corporate foster care or
516.13 community residential settings, long-term service needs within budgetary limits, including
516.14 seeking proposals from service providers or lead agencies to change service type, capacity,
516.15 or location to improve services, increase the independence of residents, and better meet
516.16 needs identified by the long-term services and supports reports and statewide data and
516.17 information.

516.18 (f) At the time of application and reapplication for licensure, the applicant and the license
516.19 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
516.20 required to inform the commissioner whether the physical location where the foster care
516.21 will be provided is or will be the primary residence of the license holder for the entire period
516.22 of licensure. If the primary residence of the applicant or license holder changes, the applicant
516.23 or license holder must notify the commissioner immediately. The commissioner shall print
516.24 on the foster care license certificate whether or not the physical location is the primary
516.25 residence of the license holder.

516.26 (g) License holders of foster care homes identified under paragraph (f) that are not the
516.27 primary residence of the license holder and that also provide services in the foster care home
516.28 that are covered by a federally approved home and community-based services waiver, as
516.29 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
516.30 services licensing division that the license holder provides or intends to provide these
516.31 waiver-funded services.

516.32 (h) The commissioner may adjust capacity to address needs identified in section
516.33 144A.351. Under this authority, the commissioner may approve new licensed settings or
516.34 delicense existing settings. Delicensing of settings will be accomplished through a process
517.1 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
517.2 information and data on capacity of licensed long-term services and supports, actions taken
517.3 under the subdivision to manage statewide long-term services and supports resources, and
517.4 any recommendations for change to the legislative committees with jurisdiction over the
517.5 health and human services budget.

517.6 (i) The commissioner must notify a license holder when its corporate foster care or
517.7 community residential setting licensed beds are reduced under this section. The notice of
517.8 reduction of licensed beds must be in writing and delivered to the license holder by certified
517.9 mail or personal service. The notice must state why the licensed beds are reduced and must
517.10 inform the license holder of its right to request reconsideration by the commissioner. The
517.11 license holder's request for reconsideration must be in writing. If mailed, the request for

436.24 residents whose primary diagnosis is mental illness and the license holder is certified under
436.25 the requirements in subdivision 6a or section 245D.33.

436.26 (e) A resource need determination process, managed at the state level, using the available
436.27 reports required by section 144A.351, and other data and information shall be used to
436.28 determine where the reduced capacity determined under section 256B.493 will be
436.29 implemented. The commissioner shall consult with the stakeholders described in section
436.30 144A.351, and employ a variety of methods to improve the state's capacity to meet the
436.31 informed decisions of those people who want to move out of corporate foster care or
436.32 community residential settings, long-term service needs within budgetary limits, including
436.33 seeking proposals from service providers or lead agencies to change service type, capacity,
436.34 or location to improve services, increase the independence of residents, and better meet
437.1 needs identified by the long-term services and supports reports and statewide data and
437.2 information.

437.3 (f) At the time of application and reapplication for licensure, the applicant and the license
437.4 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
437.5 required to inform the commissioner whether the physical location where the foster care
437.6 will be provided is or will be the primary residence of the license holder for the entire period
437.7 of licensure. If the primary residence of the applicant or license holder changes, the applicant
437.8 or license holder must notify the commissioner immediately. The commissioner shall print
437.9 on the foster care license certificate whether or not the physical location is the primary
437.10 residence of the license holder.

437.11 (g) License holders of foster care homes identified under paragraph (f) that are not the
437.12 primary residence of the license holder and that also provide services in the foster care home
437.13 that are covered by a federally approved home and community-based services waiver, as
437.14 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
437.15 services licensing division that the license holder provides or intends to provide these
437.16 waiver-funded services.

437.17 (h) The commissioner may adjust capacity to address needs identified in section
437.18 144A.351. Under this authority, the commissioner may approve new licensed settings or
437.19 delicense existing settings. Delicensing of settings will be accomplished through a process
437.20 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
437.21 information and data on capacity of licensed long-term services and supports, actions taken
437.22 under the subdivision to manage statewide long-term services and supports resources, and
437.23 any recommendations for change to the legislative committees with jurisdiction over the
437.24 health and human services budget.

437.25 (i) The commissioner must notify a license holder when its corporate foster care or
437.26 community residential setting licensed beds are reduced under this section. The notice of
437.27 reduction of licensed beds must be in writing and delivered to the license holder by certified
437.28 mail or personal service. The notice must state why the licensed beds are reduced and must
437.29 inform the license holder of its right to request reconsideration by the commissioner. The
437.30 license holder's request for reconsideration must be in writing. If mailed, the request for

517.12 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
517.13 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
517.14 reconsideration is made by personal service, it must be received by the commissioner within
517.15 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

517.16 (j) The commissioner shall not issue an initial license for children's residential treatment
517.17 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
517.18 for a program that Centers for Medicare and Medicaid Services would consider an institution
517.19 for mental diseases. Facilities that serve only private pay clients are exempt from the
517.20 moratorium described in this paragraph. The commissioner has the authority to manage
517.21 existing statewide capacity for children's residential treatment services subject to the
517.22 moratorium under this paragraph and may issue an initial license for such facilities if the
517.23 initial license would not increase the statewide capacity for children's residential treatment
517.24 services subject to the moratorium under this paragraph.

517.25 **EFFECTIVE DATE.** This section is effective July 1, 2022.

437.31 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
437.32 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
437.33 reconsideration is made by personal service, it must be received by the commissioner within
437.34 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

438.1 (j) The commissioner shall not issue an initial license for children's residential treatment
438.2 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
438.3 for a program that Centers for Medicare and Medicaid Services would consider an institution
438.4 for mental diseases. Facilities that serve only private pay clients are exempt from the
438.5 moratorium described in this paragraph. The commissioner has the authority to manage
438.6 existing statewide capacity for children's residential treatment services subject to the
438.7 moratorium under this paragraph and may issue an initial license for such facilities if the
438.8 initial license would not increase the statewide capacity for children's residential treatment
438.9 services subject to the moratorium under this paragraph.

438.10 **EFFECTIVE DATE.** This section is effective July 1, 2022.

438.11 Sec. 5. Minnesota Statutes 2020, section 256.477, is amended to read:

438.12 **256.477 SELF-ADVOCACY GRANTS.**

438.13 Subdivision 1. **The Rick Cardenas Statewide Self-Advocacy Network.** (a) The
438.14 commissioner shall make available a grant for the purposes of establishing and maintaining
438.15 a the Rick Cardenas Statewide Self-Advocacy Network for persons with intellectual and
438.16 developmental disabilities. The Rick Cardenas Statewide Self-Advocacy Network shall:

438.17 (1) ensure that persons with intellectual and developmental disabilities are informed of
438.18 their rights in employment, housing, transportation, voting, government policy, and other
438.19 issues pertinent to the intellectual and developmental disability community;

438.20 (2) provide public education and awareness of the civil and human rights issues persons
438.21 with intellectual and developmental disabilities face;

438.22 (3) provide funds, technical assistance, and other resources for self-advocacy groups
438.23 across the state; and

438.24 (4) organize systems of communications to facilitate an exchange of information between
438.25 self-advocacy groups;

438.26 (5) train and support the activities of a statewide network of peer-to-peer mentors for
438.27 persons with developmental disabilities focused on building awareness among people with
438.28 developmental disabilities of service options; assisting people with developmental disabilities
438.29 choose service options; and developing the advocacy skills of people with developmental
438.30 disabilities necessary for them to move toward full inclusion in community life, including
438.31 by developing and delivering a curriculum to support the peer-to-peer network;

439.1 (6) provide outreach activities, including statewide conferences and disability networking
439.2 opportunities, focused on self-advocacy, informed choice, and community engagement
439.3 skills; and

439.4 (7) provide an annual leadership program for persons with intellectual and developmental
439.5 disabilities.

439.6 (b) An organization receiving a grant under paragraph (a) must be an organization
439.7 governed by people with intellectual and developmental disabilities that administers a
439.8 statewide network of disability groups in order to maintain and promote self-advocacy
439.9 services and supports for persons with intellectual and developmental disabilities throughout
439.10 the state.

439.11 (c) An organization receiving a grant under this subdivision may use a portion of grant
439.12 revenue determined by the commissioner for administration and general operating costs.

439.13 Subd. 2. **Subgrants for outreach to persons in institutional settings.** The commissioner
439.14 shall make available to an organization described under subdivision 1 a grant for subgrants
439.15 to organizations in Minnesota to conduct outreach to persons working and living in
439.16 institutional settings to provide education and information about community options. Subgrant
439.17 funds must be used to deliver peer-led skill training sessions in six regions of the state to
439.18 help persons with intellectual and developmental disabilities understand community service
439.19 options related to:

439.20 (1) housing;

439.21 (2) employment;

439.22 (3) education;

439.23 (4) transportation;

439.24 (5) emerging service reform initiatives contained in the state's Olmstead plan; the
439.25 Workforce Innovation and Opportunity Act, Public Law 113-128; and federal home and
439.26 community-based services regulations; and

439.27 (6) connecting with individuals who can help persons with intellectual and developmental
439.28 disabilities make an informed choice and plan for a transition in services.

439.29 Sec. 6. **[256.4772] MINNESOTA INCLUSION INITIATIVE GRANT.**

439.30 Subdivision 1. **Grant program established.** The commissioner of human services shall
439.31 establish the Minnesota inclusion initiative grant program to encourage self-advocacy groups
439.32 of persons with intellectual and developmental disabilities to develop and organize projects
440.1 that increase the inclusion of persons with intellectual and developmental disabilities in the
440.2 community, improve community integration outcomes, educate decision-makers and the
440.3 public about persons with intellectual and developmental disabilities, including the systemic
440.4 barriers that prevent them from being included in the community, and to advocate for changes

440.5 that increase access to formal and informal supports and services necessary for greater
440.6 inclusion of persons with intellectual and developmental disabilities in the community.

440.7 Subd. 2. **Administration.** The commissioner of human services, as authorized by section
440.8 256.01, subdivision 2, paragraph (a), clause (6), shall issue a request for proposals to contract
440.9 with a public or private entity to (1) serve as a fiscal host for the money appropriated for
440.10 the purposes described in this section, and (2) develop guidelines, criteria, and procedures
440.11 for awarding grants. The fiscal host shall establish an advisory committee consisting of
440.12 self-advocates, nonprofit advocacy organizations, and Department of Human Services staff
440.13 to review applications and award grants under this section.

440.14 Subd. 3. **Applications.** (a) Entities seeking grants under this section shall apply to the
440.15 advisory committee of the fiscal host under contract with the commissioner. The grant
440.16 applicant must include a description of the project that the applicant is proposing, the amount
440.17 of money that the applicant is seeking, and a proposed budget describing how the applicant
440.18 will spend the grant money.

440.19 (b) The advisory committee may award grants to applicants only for projects that meet
440.20 the requirements of subdivision 4.

440.21 Subd. 4. **Use of grant money.** Projects funded by grant money must have person-centered
440.22 goals, call attention to issues that limit inclusion of persons with intellectual and
440.23 developmental disabilities, address barriers to inclusion that persons with intellectual and
440.24 developmental disabilities face in their communities, or increase the inclusion of persons
440.25 with intellectual and developmental disabilities in their communities. Applicants may
440.26 propose strategies to increase inclusion of persons with intellectual and developmental
440.27 disabilities in their communities by:

440.28 (1) decreasing barriers to workforce participation experienced by persons with intellectual
440.29 and developmental disabilities;

440.30 (2) overcoming barriers to accessible and reliable transportation options for persons with
440.31 intellectual and developmental disabilities;

440.32 (3) identifying and addressing barriers to voting experienced by persons with intellectual
440.33 and developmental disabilities;

441.1 (4) advocating for increased accessible housing for persons with intellectual and
441.2 developmental disabilities;

441.3 (5) working with governmental agencies or businesses on accessibility issues under the
441.4 Americans with Disabilities Act;

441.5 (6) increasing collaboration between self-advocacy groups and other organizations to
441.6 effectively address systemic issues that impact persons with intellectual and developmental
441.7 disabilities;

517.26 Sec. 3. Minnesota Statutes 2020, section 256.9741, subdivision 1, is amended to read:

517.27 Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home

517.28 licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections

517.29 144.50 to 144.56; an assisted living facility or an assisted living facility with dementia care

517.30 licensed under chapter 144G; ~~or~~ a licensed or registered residential setting that provides or

517.31 arranges for the provision of home care services; or a setting defined under section 144G.08.

441.8 (7) increasing capacity for inclusion in a community; or

441.9 (8) providing public education and awareness of the civil and human rights of persons

441.10 with intellectual and developmental disabilities.

441.11 Subd. 5. **Reports.** (a) Grant recipients shall provide the advisory committee with a report

441.12 about the activities funded by the grant program in a format and at a time specified by the

441.13 advisory committee. The advisory committee shall require grant recipients to include in the

441.14 grant recipient's report at least the information necessary for the advisory committee to meet

441.15 the advisory committee's obligation under paragraph (b).

441.16 (b) The advisory committee shall provide the commissioner with a report that describes

441.17 all of the activities and outcomes of projects funded by the grant program in a format and

441.18 at a time determined by the commissioner.

441.19 Sec. 7. **[256.4776] PARENT-TO-PARENT PEER SUPPORT.**

441.20 (a) The commissioner shall make a grant to an alliance member of Parent to Parent USA

441.21 to support the alliance member's parent-to-parent peer support program for families of

441.22 children with any type of disability or special health care needs. An eligible alliance member

441.23 must have an established parent-to-parent peer support program that is statewide and

441.24 represents diverse cultures and geographic locations, that conducts outreach and provides

441.25 individualized support to any parent or guardian of a child with a disability or special health

441.26 care need, including newly identified parents of such a child or parents experiencing

441.27 transitions or changes in their child's care, and that implements best practices for peer-to-peer

441.28 support, including providing support from trained parent staff and volunteer support parents

441.29 who have received Parent to Parent USA's specialized parent-to-parent peer support training.

441.30 (b) Grant recipients must use grant money for the purposes specified in paragraph (a).

442.1 (c) For purposes of this section, "special health care needs" means disabilities, chronic

442.2 illnesses or conditions, health-related educational or behavioral problems, or the risk of

442.3 developing disabilities, conditions, illnesses, or problems.

442.4 (d) Grant recipients must report to the commissioner of human services annually by

442.5 January 15 about the services and programs funded by this grant. The report must include

442.6 measurable outcomes from the previous year, including the number of families served by

442.7 the organization's parent-to-parent programs and the number of volunteer support parents

442.8 trained by the organization's parent-to-parent programs.

517.32 subdivision 7, clauses (10) to (13), that provides or arranges for the provision of home care
517.33 services.
517.34 **EFFECTIVE DATE.** This section is effective August 1, 2021.

442.9 Sec. 8. Minnesota Statutes 2020, section 256B.0653, is amended by adding a subdivision
442.10 to read:
442.11 Subd. 8. **Payment rates for home health agency services.** The commissioner shall
442.12 annually adjust payments for home health agency services to reflect the change in the federal
442.13 Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The
442.14 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to
442.15 the midpoint of the current rate year.
442.16 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
442.17 whichever occurs later, for services delivered on or after January 1, 2022. The commissioner
442.18 of human services shall notify the revisor of statutes when federal approval is obtained.
442.19 Sec. 9. Minnesota Statutes 2020, section 256B.0654, is amended by adding a subdivision
442.20 to read:
442.21 Subd. 5. **Payment rates for home care nursing services.** The commissioner shall
442.22 annually adjust payments for home care nursing services to reflect the change in the federal
442.23 Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The
442.24 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to
442.25 the midpoint of the current rate year.
442.26 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
442.27 whichever occurs later, for services delivered on or after January 1, 2022. The commissioner
442.28 of human services shall notify the revisor of statutes when federal approval is obtained.
442.29 Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 11, is amended to read:
442.30 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
442.31 meet the following requirements:
443.1 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
443.2 age with these additional requirements:
443.3 (i) supervision by a qualified professional every 60 days; and
443.4 (ii) employment by only one personal care assistance provider agency responsible for
443.5 compliance with current labor laws;
443.6 (2) be employed by a personal care assistance provider agency;
443.7 (3) enroll with the department as a personal care assistant after clearing a background
443.8 study. Except as provided in subdivision 11a, before a personal care assistant provides

443.9 services, the personal care assistance provider agency must initiate a background study on
443.10 the personal care assistant under chapter 245C, and the personal care assistance provider
443.11 agency must have received a notice from the commissioner that the personal care assistant
443.12 is:

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

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

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

443.18 (5) be able to provide covered personal care assistance services according to the recipient's
443.19 personal care assistance care plan, respond appropriately to recipient needs, and report
443.20 changes in the recipient's condition to the supervising qualified professional, physician, or
443.21 advanced practice registered nurse;

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

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

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

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

444.4 (10) be limited to providing and being paid for up to 310 hours per month of personal
444.5 care assistance services regardless of the number of recipients being served or the number
444.6 of personal care assistance provider agencies enrolled with. The number of hours worked
444.7 per day shall not be disallowed by the department unless in violation of the law.

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

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

518.1 Sec. 4. Minnesota Statutes 2020, section 256B.0659, is amended by adding a subdivision
518.2 to read:

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

518.9 Sec. 5. Minnesota Statutes 2020, section 256B.0659, is amended by adding a subdivision
518.10 to read:

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

444.14 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
444.15 17a if the personal care assistant providing the services:

444.16 (1) provides covered services to a recipient who qualifies for ~~12~~ ten or more hours per
444.17 day of personal care assistance services; and

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

444.22 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
444.23 whichever occurs later. The commissioner shall notify the revisor of statutes when federal
444.24 approval is obtained.

444.25 Sec. 11. Minnesota Statutes 2020, section 256B.0659, subdivision 17a, is amended to
444.26 read:

444.27 Subd. 17a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for
444.28 personal care assistance services shall be paid for services provided to persons who qualify
444.29 for ~~12~~ ten or more hours of personal care assistance services per day when provided by a
444.30 personal care assistant who meets the requirements of subdivision 11, paragraph (d). The
444.31 enhanced rate for personal care assistance services includes, and is not in addition to, any
444.32 rate adjustments implemented by the commissioner on July 1, 2019, to comply with the
445.1 terms of a collective bargaining agreement between the state of Minnesota and an exclusive
445.2 representative of individual providers under section 179A.54, that provides for wage increases
445.3 for individual providers who serve participants assessed to need 12 or more hours of personal
445.4 care assistance services per day.

445.5 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
445.6 whichever occurs later. The commissioner shall notify the revisor of statutes when federal
445.7 approval is obtained.

518.15 Sec. 6. Minnesota Statutes 2020, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

520.29 ~~(c)~~ (d) All personal care assistance provider agencies shall require all employees in
520.30 management and supervisory positions and owners of the agency who are active in the
520.31 day-to-day management and operations of the agency to complete mandatory training as
520.32 determined by the commissioner before submitting an application for enrollment of the
520.33 agency as a provider. The mandatory training, or any substantially similar refresher training
520.34 developed by the commissioner, must be completed every two years thereafter. All personal
521.1 care assistance provider agencies shall also require qualified professionals to complete the
521.2 training required by subdivision 13 before submitting an application for enrollment of the
521.3 agency as a provider. Employees in management and supervisory positions and owners who
521.4 are active in the day-to-day operations of an agency who have completed the required
521.5 training as an employee with a personal care assistance provider agency do not need to
521.6 repeat the required training if they are hired by another agency, if they have completed the
521.7 training within the past three two years. By September 1, 2010, The required training must
521.8 be available with meaningful access according to title VI of the Civil Rights Act and federal
521.9 regulations adopted under that law or any guidance from the United States Health and
521.10 Human Services Department. The required training must be available online or by electronic
521.11 remote connection. The required training must provide for competency testing. Personal
521.12 care assistance provider agency billing staff shall complete training about personal care
521.13 assistance program financial management. This training is effective July 1, 2009. Any
521.14 personal care assistance provider agency enrolled before that date shall, if it has not already,
521.15 complete the provider training within 18 months of July 1, 2009. Any new owners or
521.16 employees in management and supervisory positions involved in the day-to-day operations
521.17 are required to complete mandatory training as a requisite of working for the agency. Personal
521.18 care assistance provider agencies certified for participation in Medicare as home health
521.19 agencies are exempt from the training required in this subdivision. When available,
521.20 Medicare-certified home health agency owners, supervisors, or managers must successfully
521.21 complete the competency test.

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

521.29 (f) Personal care assistance provider agencies enrolling for the first time must also
521.30 provide, at the time of enrollment as a personal care assistance provider agency in a format
521.31 determined by the commissioner, information and documentation. The information and

521.32 documentation must include proof of sufficient initial operating capital to support the
521.33 infrastructure necessary to allow for ongoing compliance with the requirements of this
521.34 section. Sufficient operating capital may be demonstrated as follows:

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

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

522.3 (3) any other manner prescribed by the commissioner.

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

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

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

522.11 Sec. 7. Minnesota Statutes 2020, section 256B.0659, subdivision 24, is amended to read:

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

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

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

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

522.19 (4) comply with background study requirements;

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

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

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

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

522.27 (9) document that the agency uses a minimum of 72.5 percent of the revenue generated
522.28 by the medical assistance rate for personal care assistance services for employee personal
522.29 care assistant wages and benefits. The revenue generated by the qualified professional and

522.30 the reasonable costs associated with the qualified professional shall not be used in making
522.31 this calculation;

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

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

523.4 (12) report suspected neglect and abuse to the common entry point according to section
523.5 256B.0651;

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

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

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

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

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

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

445.8 Sec. 12. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

- 445.18 (5) face-to-face long-term care consultation assessments, which may be completed in a
445.19 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
445.20 (ICF/DDs), regional treatment centers, or the person's current or planned residence;
- 445.21 (6) determination of home and community-based waiver and other service eligibility as
445.22 required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including
445.23 level of care determination for individuals who need an institutional level of care as
445.24 determined under subdivision 4e, based on a long-term care consultation assessment and
445.25 community support plan development, appropriate referrals to obtain necessary diagnostic
445.26 information, and including an eligibility determination for consumer-directed community
445.27 supports;
- 445.28 (7) providing recommendations for institutional placement when there are no
445.29 cost-effective community services available;
- 445.30 (8) providing access to assistance to transition people back to community settings after
445.31 institutional admission;
- 446.1 (9) providing information about competitive employment, with or without supports, for
446.2 school-age youth and working-age adults and referrals to the Disability Hub and Disability
446.3 Benefits 101 to ensure that an informed choice about competitive employment can be made.
446.4 For the purposes of this subdivision, "competitive employment" means work in the
446.5 competitive labor market that is performed on a full-time or part-time basis in an integrated
446.6 setting, and for which an individual is compensated at or above the minimum wage, but not
446.7 less than the customary wage and level of benefits paid by the employer for the same or
446.8 similar work performed by individuals without disabilities;
- 446.9 (10) providing information about independent living to ensure that an informed choice
446.10 about independent living can be made; and
- 446.11 (11) providing information about self-directed services and supports, including
446.12 self-directed funding options, to ensure that an informed choice about self-directed options
446.13 can be made.
- 446.14 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
446.15 and 3a, "long-term care consultation services" also means:
- 446.16 (1) service eligibility determination for the following state plan services:
- 446.17 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;
- 446.18 (ii) consumer support grants under section 256.476; or
- 446.19 (iii) community first services and supports under section 256B.85;
- 446.20 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
446.21 gaining access to;

- 446.22 (i) relocation targeted case management services available under section 256B.0621,
446.23 subdivision 2, clause (4);
- 446.24 (ii) case management services targeted to vulnerable adults or developmental disabilities
446.25 under section 256B.0924; and
- 446.26 (iii) case management services targeted to people with developmental disabilities under
446.27 Minnesota Rules, part 9525.0016;
- 446.28 (3) determination of eligibility for semi-independent living services under section
446.29 252.275; and
- 446.30 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
446.31 and (3).
- 447.1 (c) "Long-term care options counseling" means the services provided by sections 256.01,
447.2 subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and
447.3 follow up once a long-term care consultation assessment has been completed.
- 447.4 (d) "Minnesota health care programs" means the medical assistance program under this
447.5 chapter and the alternative care program under section 256B.0913.
- 447.6 (e) "Lead agencies" means counties administering or tribes and health plans under
447.7 contract with the commissioner to administer long-term care consultation services.
- 447.8 (f) "Person-centered planning" is a process that includes the active participation of a
447.9 person in the planning of the person's services, including in making meaningful and informed
447.10 choices about the person's own goals, talents, and objectives, as well as making meaningful
447.11 and informed choices about the services the person receives, the settings in which the person
447.12 receives the services, and the setting in which the person lives.
- 447.13 (g) "Informed choice" means a voluntary choice of services, settings, living arrangement,
447.14 and work by a person from all available service and setting options based on accurate and
447.15 complete information concerning all available service and setting options and concerning
447.16 the person's own preferences, abilities, goals, and objectives. In order for a person to make
447.17 an informed choice, all available options must be developed and presented to the person in
447.18 a way the person can understand to empower the person to make fully informed choices
447.19 has the meaning given in section 256B.4905, subdivision 1a, paragraph (b).
- 447.20 (h) "Available service and setting options" or "available options," with respect to the
447.21 home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49,
447.22 means all services and settings defined under the waiver plan for which a waiver applicant
447.23 or waiver participant is eligible.
- 447.24 (i) "Independent living" means living in a setting that is not controlled by a provider.

523.22 Sec. 8. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

523.23 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
523.24 planning, or other assistance intended to support community-based living, including persons
523.25 who need assessment in order to determine waiver or alternative care program eligibility,
523.26 must be visited by a long-term care consultation team within 20 calendar days after the date
523.27 on which an assessment was requested or recommended. Upon statewide implementation
523.28 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
523.29 requesting personal care assistance services. The commissioner shall provide at least a
523.30 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face
523.31 assessments must be conducted according to paragraphs (b) to (i).

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

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

524.9 (d) The assessment must be conducted by a certified assessor in a face-to-face
524.10 conversational interview with the person being assessed. The person's legal representative
524.11 must provide input during the assessment process and may do so remotely if requested. At
524.12 the request of the person, other individuals may participate in the assessment to provide
524.13 information on the needs, strengths, and preferences of the person necessary to develop a
524.14 community support plan that ensures the person's health and safety. Except for legal
524.15 representatives or family members invited by the person, persons participating in the
524.16 assessment may not be a provider of service or have any financial interest in the provision
524.17 of services. For persons who are to be assessed for elderly waiver customized living or adult
524.18 day services under chapter 256S, with the permission of the person being assessed or the
524.19 person's designated or legal representative, the client's current or proposed provider of
524.20 services may submit a copy of the provider's nursing assessment or written report outlining
524.21 its recommendations regarding the client's care needs. The person conducting the assessment
524.22 must notify the provider of the date by which this information is to be submitted. This
524.23 information shall be provided to the person conducting the assessment prior to the assessment.
524.24 For a person who is to be assessed for waiver services under section 256B.092 or 256B.49,
524.25 with the permission of the person being assessed or the person's designated legal
524.26 representative, the person's current provider of services may submit a written report outlining
524.27 recommendations regarding the person's care needs the person completed in consultation
524.28 with someone who is known to the person and has interaction with the person on a regular
524.29 basis. The provider must submit the report at least 60 days before the end of the person's
524.30 current service agreement. The certified assessor must consider the content of the submitted
524.31 report prior to finalizing the person's assessment or reassessment.

447.25 Sec. 13. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

447.26 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
447.27 planning, or other assistance intended to support community-based living, including persons
447.28 who need assessment in order to determine waiver or alternative care program eligibility,
447.29 must be visited by a long-term care consultation team within 20 calendar days after the date
447.30 on which an assessment was requested or recommended. Upon statewide implementation
447.31 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
447.32 requesting personal care assistance services. The commissioner shall provide at least a
448.1 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face
448.2 assessments must be conducted according to paragraphs (b) to (i).

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

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

448.11 (d) The assessment must be conducted by a certified assessor in a face-to-face
448.12 conversational interview with the person being assessed. The person's legal representative
448.13 must provide input during the assessment process and may do so remotely if requested. At
448.14 the request of the person, other individuals may participate in the assessment to provide
448.15 information on the needs, strengths, and preferences of the person necessary to develop a
448.16 community support plan that ensures the person's health and safety. Except for legal
448.17 representatives or family members invited by the person, persons participating in the
448.18 assessment may not be a provider of service or have any financial interest in the provision
448.19 of services. For persons who are to be assessed for elderly waiver customized living or adult
448.20 day services under chapter 256S, with the permission of the person being assessed or the
448.21 person's designated or legal representative, the client's current or proposed provider of
448.22 services may submit a copy of the provider's nursing assessment or written report outlining
448.23 its recommendations regarding the client's care needs. The person conducting the assessment
448.24 must notify the provider of the date by which this information is to be submitted. This
448.25 information shall be provided to the person conducting the assessment prior to the assessment.
448.26 For a person who is to be assessed for waiver services under section 256B.092 or 256B.49,
448.27 with the permission of the person being assessed or the person's designated legal
448.28 representative, the person's current provider of services may submit a written report outlining
448.29 recommendations regarding the person's care needs the person completed in consultation
448.30 with someone who is known to the person and has interaction with the person on a regular
448.31 basis. The provider must submit the report at least 60 days before the end of the person's
448.32 current service agreement. The certified assessor must consider the content of the submitted
448.33 report prior to finalizing the person's assessment or reassessment.

524.32 (e) The certified assessor and the individual responsible for developing the coordinated
524.33 service and support plan must complete the community support plan and the coordinated
524.34 service and support plan no more than 60 calendar days from the assessment visit. The
524.35 person or the person's legal representative must be provided with a written community
525.1 support plan within the timelines established by the commissioner, regardless of whether
525.2 the person is eligible for Minnesota health care programs.

525.3 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
525.4 who submitted information under paragraph (d) shall receive the final written community
525.5 support plan when available and the Residential Services Workbook.

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

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

525.8 (2) the individual's options and choices to meet identified needs, including:

525.9 (i) all available options for case management services and providers;

525.10 (ii) all available options for employment services, settings, and providers;

525.11 (iii) all available options for living arrangements;

525.12 (iv) all available options for self-directed services and supports, including self-directed
525.13 budget options; and

525.14 (v) service provided in a non-disability-specific setting;

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

525.17 (4) referral information; and

525.18 (5) informal caregiver supports, if applicable.

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

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

525.27 (i) The person has the right to make the final decision:

525.28 (1) between institutional placement and community placement after the recommendations
525.29 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

448.34 (e) The certified assessor and the individual responsible for developing the coordinated
448.35 service and support plan must complete the community support plan and the coordinated
449.1 service and support plan no more than 60 calendar days from the assessment visit. The
449.2 person or the person's legal representative must be provided with a written community
449.3 support plan within the timelines established by the commissioner, regardless of whether
449.4 the person is eligible for Minnesota health care programs.

449.5 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
449.6 who submitted information under paragraph (d) shall receive the final written community
449.7 support plan when available and the Residential Services Workbook.

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

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

449.10 (2) the individual's options and choices to meet identified needs, including:

449.11 (i) all available options for case management services and providers;

449.12 (ii) all available options for employment services, settings, and providers;

449.13 (iii) all available options for living arrangements;

449.14 (iv) all available options for self-directed services and supports, including self-directed
449.15 budget options; and

449.16 (v) service provided in a non-disability-specific setting;

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

449.19 (4) referral information; and

449.20 (5) informal caregiver supports, if applicable.

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

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

449.29 (i) The person has the right to make the final decision:

449.30 (1) between institutional placement and community placement after the recommendations
449.31 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

526.1 (2) between community placement in a setting controlled by a provider and living
526.2 independently in a setting not controlled by a provider;

526.3 (3) between day services and employment services; and

526.4 (4) regarding available options for self-directed services and supports, including
526.5 self-directed funding options.

526.6 (j) The lead agency must give the person receiving long-term care consultation services
526.7 or the person's legal representative, materials, and forms supplied by the commissioner
526.8 containing the following information:

526.9 (1) written recommendations for community-based services and consumer-directed
526.10 options;

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

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

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

526.27 (5) information about Minnesota health care programs;

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

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

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

527.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
527.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and

450.1 (2) between community placement in a setting controlled by a provider and living
450.2 independently in a setting not controlled by a provider;

450.3 (3) between day services and employment services; and

450.4 (4) regarding available options for self-directed services and supports, including
450.5 self-directed funding options.

450.6 (j) The lead agency must give the person receiving long-term care consultation services
450.7 or the person's legal representative, materials, and forms supplied by the commissioner
450.8 containing the following information:

450.9 (1) written recommendations for community-based services and consumer-directed
450.10 options;

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

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

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

450.27 (5) information about Minnesota health care programs;

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

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

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

451.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
451.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and

527.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
527.6 or the lead agency's final decisions regarding public programs eligibility according to section
527.7 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
527.8 to the person and must visually point out where in the document the right to appeal is stated;
527.9 and

527.10 (10) documentation that available options for employment services, independent living,
527.11 and self-directed services and supports were described to the individual.

527.12 (k) Face-to-face assessment completed as part of an eligibility determination for multiple
527.13 programs for the alternative care, elderly waiver, developmental disabilities, community
527.14 access for disability inclusion, community alternative care, and brain injury waiver programs
527.15 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
527.16 service eligibility for no more than 60 calendar days after the date of assessment.

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

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

527.28 (n) If a person who receives home- and community-based waiver services under section
527.29 256B.0913, 256B.092, or 256B.49, or chapter 256S, temporarily enters for 121 days or less
527.30 a hospital, institution of mental disease, nursing facility, intensive residential treatment
527.31 services program, transitional care unit, or inpatient substance use disorder treatment setting,
527.32 the person may return to the community with home- and community-based waiver services
527.33 under the same waiver, without requiring an assessment or reassessment under this section,
527.34 unless the person's annual reassessment is otherwise due. Nothing in this section shall change
528.1 annual long-term care consultation reassessment requirements, payment for institutional or
528.2 treatment services, medical assistance financial eligibility, or any other law.

528.3 ~~(n)~~ (o) At the time of reassessment, the certified assessor shall assess each person
528.4 receiving waiver residential supports and services currently residing in a community
528.5 residential setting, licensed adult foster care home that is either not the primary residence
528.6 of the license holder or in which the license holder is not the primary caregiver, family adult
528.7 foster care residence, customized living setting, or supervised living facility to determine
528.8 if that person would prefer to be served in a community-living setting as defined in section
528.9 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated
528.10 community supports as described in section 245D.03, subdivision 1, paragraph (c), clause

451.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
451.6 or the lead agency's final decisions regarding public programs eligibility according to section
451.7 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
451.8 to the person and must visually point out where in the document the right to appeal is stated;
451.9 and

451.10 (10) documentation that available options for employment services, independent living,
451.11 and self-directed services and supports were described to the individual.

451.12 (k) Face-to-face assessment completed as part of an eligibility determination for multiple
451.13 programs for the alternative care, elderly waiver, developmental disabilities, community
451.14 access for disability inclusion, community alternative care, and brain injury waiver programs
451.15 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
451.16 service eligibility for no more than 60 calendar days after the date of assessment.

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

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

451.28 (n) If a person who receives home and community-based waiver services under section
451.29 256B.0913, 256B.092, or 256B.49 or chapter 256S temporarily enters for 121 days or fewer
451.30 a hospital, institution of mental disease, nursing facility, intensive residential treatment
451.31 services program, transitional care unit, or inpatient substance use disorder treatment setting,
451.32 the person may return to the community with home and community-based waiver services
451.33 under the same waiver, without requiring an assessment or reassessment under this section,
451.34 unless the person's annual reassessment is otherwise due. Nothing in this paragraph shall
452.1 change annual long-term care consultation reassessment requirements, payment for
452.2 institutional or treatment services, medical assistance financial eligibility, or any other law.

452.3 ~~(n)~~ (o) At the time of reassessment, the certified assessor shall assess each person
452.4 receiving waiver residential supports and services currently residing in a community
452.5 residential setting, licensed adult foster care home that is either not the primary residence
452.6 of the license holder or in which the license holder is not the primary caregiver, family adult
452.7 foster care residence, customized living setting, or supervised living facility to determine
452.8 if that person would prefer to be served in a community-living setting as defined in section
452.9 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated
452.10 community supports as described in section 245D.03, subdivision 1, paragraph (c), clause

528.11 (8). The certified assessor shall offer the person, through a person-centered planning process,
528.12 the option to receive alternative housing and service options.

528.13 ~~(p)~~ (p) At the time of reassessment, the certified assessor shall assess each person
528.14 receiving waiver day services to determine if that person would prefer to receive employment
528.15 services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7).
528.16 The certified assessor shall describe to the person through a person-centered planning process
528.17 the option to receive employment services.

528.18 ~~(p)~~ (q) At the time of reassessment, the certified assessor shall assess each person
528.19 receiving non-self-directed waiver services to determine if that person would prefer an
528.20 available service and setting option that would permit self-directed services and supports.
528.21 The certified assessor shall describe to the person through a person-centered planning process
528.22 the option to receive self-directed services and supports.

528.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
528.24 shall notify the revisor of statutes when federal approval is obtained.

452.11 (8). The certified assessor shall offer the person, through a person-centered planning process,
452.12 the option to receive alternative housing and service options.

452.13 ~~(p)~~ (p) At the time of reassessment, the certified assessor shall assess each person
452.14 receiving waiver day services to determine if that person would prefer to receive employment
452.15 services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7).
452.16 The certified assessor shall describe to the person through a person-centered planning process
452.17 the option to receive employment services.

452.18 ~~(p)~~ (q) At the time of reassessment, the certified assessor shall assess each person
452.19 receiving non-self-directed waiver services to determine if that person would prefer an
452.20 available service and setting option that would permit self-directed services and supports.
452.21 The certified assessor shall describe to the person through a person-centered planning process
452.22 the option to receive self-directed services and supports.

452.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
452.24 shall notify the revisor of statutes when federal approval is obtained.

452.25 Sec. 14. Minnesota Statutes 2020, section 256B.0911, subdivision 6, is amended to read:

452.26 Subd. 6. **Payment for long-term care consultation services.** ~~(a) Until September 30,~~
452.27 ~~2013, payment for long-term care consultation face-to-face assessment shall be made as~~
452.28 ~~described in this subdivision.~~

452.29 ~~(b) The total payment for each county must be paid monthly by Certified nursing facilities~~
452.30 ~~in the county. The monthly amount to be paid by each nursing facility for each fiscal year~~
452.31 ~~must be determined by dividing the county's annual allocation for long-term care consultation~~
452.32 ~~services by 12 to determine the monthly payment and allocating the monthly payment to~~
452.33 ~~each nursing facility based on the number of licensed beds in the nursing facility. Payments~~
453.1 ~~to counties in which there is no certified nursing facility must be made by increasing the~~
453.2 ~~payment rate of the two facilities located nearest to the county seat.~~

453.3 ~~(c) The commissioner shall include the total annual payment determined under paragraph~~
453.4 ~~(b) for each nursing facility reimbursed under section 256B.431 or 256B.434 or chapter~~
453.5 ~~256R.~~

453.6 ~~(d) In the event of the layaway, delicensure and decertification, or removal from layaway~~
453.7 ~~of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem~~
453.8 ~~payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph~~
453.9 ~~(b). The effective date of an adjustment made under this paragraph shall be on or after the~~
453.10 ~~first day of the month following the effective date of the layaway, delicensure and~~
453.11 ~~decertification, or removal from layaway.~~

453.12 ~~(e) (a) Payments for long-term care consultation services are available to the county or~~
453.13 ~~counties and Tribal nations that are lead agencies to cover staff salaries and expenses to~~
453.14 ~~provide the services described in subdivision 1a. The county or Tribal nation shall employ,~~
453.15 ~~or contract with other agencies to employ, within the limits of available funding, sufficient~~

453.16 personnel to provide long-term care consultation services while meeting the state's long-term
453.17 care outcomes and objectives as defined in subdivision 1. The county or Tribal nation shall
453.18 be accountable for meeting local objectives as approved by the commissioner in the biennial
453.19 home and community-based services quality assurance plan on a form provided by the
453.20 commissioner.

453.21 ~~(f) Notwithstanding section 256B.0641, overpayments attributable to payment of the~~
453.22 ~~screening costs under the medical assistance program may not be recovered from a facility.~~

453.23 ~~(g) The commissioner of human services shall amend the Minnesota medical assistance~~
453.24 ~~plan to include reimbursement for the local consultation teams.~~

453.25 ~~(h) Until the alternative payment methodology in paragraph (i) is implemented, the~~
453.26 ~~county may bill, as case management services, assessments, support planning, and~~
453.27 ~~follow along provided to persons determined to be eligible for case management under~~
453.28 ~~Minnesota health care programs.~~

453.29 (b) No individual or family member shall be charged for an initial assessment or initial
453.30 support plan development provided under subdivision 3a or 3b.

453.31 ~~(+)~~ (c) The commissioner shall develop an alternative payment methodology, effective
453.32 on October 1, 2013, for long-term care consultation services that includes the funding
453.33 available under this subdivision, and for assessments authorized under sections 256B.092
454.1 and 256B.0659. In developing the new payment methodology, the commissioner shall
454.2 consider the maximization of other funding sources, including federal administrative
454.3 reimbursement through federal financial participation funding, for all long-term care
454.4 consultation activity. The alternative payment methodology shall include the use of the
454.5 appropriate time studies and the state financing of nonfederal share as part of the state's
454.6 medical assistance program. Between July 1, 2017, and June 30, 2019, the state shall pay
454.7 84.3 percent of the nonfederal share as reimbursement to the counties. Beginning July 1,
454.8 2019, the state shall pay 81.9 percent of the nonfederal share as reimbursement to the
454.9 counties.

454.10 Sec. 15. Minnesota Statutes 2020, section 256B.0911, is amended by adding a subdivision
454.11 to read:

454.12 Subd. 6b. **Payment for long-term care consultation services; transition to tiered**
454.13 **rates.** (a) Notwithstanding subdivision 6, paragraph (c), beginning July 1, 2021, for each
454.14 fiscal year through fiscal year 2025, the state shall pay to each county and Tribal nation as
454.15 reimbursement for services provided under this section a percentage of the nonfederal share
454.16 equal to the value of the county's or the Tribal nation's prorated share of the nonfederal
454.17 share paid to counties and Tribal nations as reimbursement for services provided under
454.18 subdivision 6, paragraph (c), during fiscal year 2019.

454.19 (b) Beginning October 1, 2022, each county or Tribal nation reimbursed under paragraph
454.20 (a) must submit to the commissioner by October 1 an annual report documenting the total
454.21 number of assessments performed under this section, the number of assessments by type of

454.22 assessment, amount of time spent on each assessment, amount of time spent preparing for
454.23 each assessment, amount of time spent finalizing a community support plan following each
454.24 assessment, and amount of time an assessor spent on other assessment-related activities for
454.25 each assessment. In its annual report, each county and Tribal nation must distinguish between
454.26 services provided to people who were eligible for medical assistance at the time the services
454.27 were provided and services provided to those who were not.

454.28 (c) This subdivision expires July 1, 2025.

454.29 Sec. 16. Minnesota Statutes 2020, section 256B.092, subdivision 1b, is amended to read:

454.30 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
454.31 community-based waived services shall be provided a copy of the written person-centered
454.32 coordinated service and support plan that:

455.1 (1) is developed with and signed by the recipient within the timelines established by the
455.2 commissioner and section 256B.0911, subdivision 3a, paragraph (e);

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

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

455.7 (4) identifies the person's preferences for services as stated by the person, the person's
455.8 legal guardian or conservator, or the parent if the person is a minor, including the person's
455.9 choices made on self-directed options, services and supports to achieve employment goals,
455.10 and living arrangements;

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

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

455.15 (7) identifies specific services and the amount and frequency of the services to be provided
455.16 to the person based on assessed needs, preferences, and available resources. The
455.17 person-centered coordinated service and support plan shall also specify other services the
455.18 person needs that are not available and indicate in a clear and accessible manner the total
455.19 monetary resources available to meet the assessed needs and preferences of the individual;

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

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

528.25 Sec. 9. Minnesota Statutes 2020, section 256B.092, subdivision 4, is amended to read:

528.26 Subd. 4. **Home and community-based services for developmental disabilities.** (a)
528.27 The commissioner shall make payments to approved vendors participating in the medical
528.28 assistance program to pay costs of providing home and community-based services, including
528.29 case management service activities provided as an approved home and community-based
528.30 service, to medical assistance eligible persons with developmental disabilities who have
528.31 been screened under subdivision 7 and according to federal requirements. Federal
528.32 requirements include those services and limitations included in the federally approved
528.33 application for home and community-based services for persons with developmental
528.34 disabilities and subsequent amendments.

529.1 (b) Effective July 1, 1995, contingent upon federal approval and state appropriations
529.2 made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8,
529.3 section 40, the commissioner of human services shall allocate resources to county agencies
529.4 for home and community-based waived services for persons with developmental disabilities
529.5 authorized but not receiving those services as of June 30, 1995, based upon the average
529.6 resource need of persons with similar functional characteristics. To ensure service continuity
529.7 for service recipients receiving home and community-based waived services for persons
529.8 with developmental disabilities prior to July 1, 1995, the commissioner shall make available
529.9 to the county of financial responsibility home and community-based waived services
529.10 resources based upon fiscal year 1995 authorized levels.

529.11 (c) Home and community-based resources for all recipients shall be managed by the
529.12 county of financial responsibility within an allowable reimbursement average established
529.13 for each county. Payments for home and community-based services provided to individual
529.14 recipients shall not exceed amounts authorized by the county of financial responsibility.

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

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

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

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

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

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

529.15 ~~For specifically identified former residents of nursing facilities, the commissioner shall be~~
529.16 ~~responsible for authorizing payments and payment limits under the appropriate home and~~
529.17 ~~community-based service program. Payment is available under this subdivision only for~~
529.18 ~~persons who, if not provided these services, would require the level of care provided in an~~
529.19 ~~intermediate care facility for persons with developmental disabilities.~~

529.20 ~~(d)~~ (b) The commissioner shall comply with the requirements in the federally approved
529.21 transition plan for the home and community-based services waivers for the elderly authorized
529.22 under this section.

529.23 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
529.24 whichever is later. The commissioner of human services shall notify the revisor of statutes
529.25 when federal approval is obtained.

529.26 Sec. 10. Minnesota Statutes 2020, section 256B.092, subdivision 5, is amended to read:

529.27 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers
529.28 necessary to secure, to the extent allowed by law, federal financial participation under United
529.29 States Code, title 42, sections 1396 et seq., as amended, for the provision of services to
529.30 persons who, in the absence of the services, would need the level of care provided in a
529.31 regional treatment center or a community intermediate care facility for persons with
529.32 developmental disabilities. The commissioner may seek amendments to the waivers or apply
529.33 for additional waivers under United States Code, title 42, sections 1396 et seq., as amended,
529.34 to contain costs. The commissioner shall ensure that payment for the cost of providing home
530.1 and community-based alternative services under the federal waiver plan shall not exceed
530.2 the cost of intermediate care services including day training and habilitation services that
530.3 would have been provided without the waived services.

530.4 The commissioner shall seek an amendment to the 1915c home and community-based
530.5 waiver to allow properly licensed adult foster care homes to provide residential services to
530.6 up to five individuals with developmental disabilities. If the amendment to the waiver is
530.7 approved, adult foster care providers that can accommodate five individuals shall increase
530.8 their capacity to five beds, provided the providers continue to meet all applicable licensing
530.9 requirements.

530.10 (b) The commissioner, in administering home and community-based waivers for persons
530.11 with developmental disabilities, shall ensure that day services for eligible persons are not
530.12 provided by the person's residential service provider, unless the person or the person's legal
530.13 representative is offered a choice of providers and agrees in writing to provision of day
530.14 services by the residential service provider. The coordinated service and support plan for
530.15 individuals who choose to have their residential service provider provide their day services
530.16 must describe how health, safety, protection, and habilitation needs will be met, including
530.17 how frequent and regular contact with persons other than the residential service provider
530.18 will occur. The coordinated service and support plan must address the provision of services
530.19 during the day outside the residence on weekdays.

530.20 (c) When a lead agency is evaluating denials, reductions, or terminations of home and
530.21 community-based services under section 256B.0916 for an individual, the lead agency shall
530.22 offer to meet with the individual or the individual's guardian in order to discuss the
530.23 prioritization of service needs within the coordinated service and support plan. The reduction
530.24 in the authorized services for an individual due to changes in funding for waived services
530.25 may not exceed the amount needed to ensure medically necessary services to meet the
530.26 individual's health, safety, and welfare.

530.27 (d) The commissioner shall seek federal approval to allow for the reconfiguration of the
530.28 1915(c) home and community-based waivers in this section, as authorized under section
530.29 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

530.30 (e) The transition to two disability home and community-based services waiver programs
530.31 must align with the independent living first policy under section 256B.4905. Unless
530.32 superseded by any other state or federal law, waiver eligibility criteria shall be the same for
530.33 each waiver. The waiver program that a person uses shall be determined by the support
531.1 planning process and whether the person chooses to live in a provider-controlled setting or
531.2 in the person's own home.

531.3 (f) The commissioner shall seek federal approval for the 1915(c) home and
531.4 community-based waivers in this section, as authorized under section 1915(c) of the federal
531.5 Social Security Act, to implement an individual resource allocation methodology.

531.6 **EFFECTIVE DATE.** This section is effective January 1, 2023, or 90 days after federal
531.7 approval, whichever is later. The commissioner of human services shall notify the revisor
531.8 of statutes when federal approval is obtained.

531.9 Sec. 11. Minnesota Statutes 2020, section 256B.092, subdivision 12, is amended to read:

531.10 Subd. 12. ~~Waived Waiver services statewide priorities.~~ (a) The commissioner shall
531.11 establish statewide priorities for individuals on the waiting list for developmental disabilities
531.12 (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are
531.13 not limited to, individuals who continue to have a need for waiver services after they have
531.14 maximized the use of state plan services and other funding resources, including natural
531.15 supports, prior to accessing waiver services, and who meet at least one of the following
531.16 criteria:

531.17 (1) no longer require the intensity of services provided where they are currently living;
531.18 or

531.19 (2) make a request to move from an institutional setting.

531.20 (b) After the priorities in paragraph (a) are met, priority must also be given to individuals
531.21 who meet at least one of the following criteria:

531.22 (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary
531.23 caregivers;

531.24 (2) are moving from an institution due to bed closures;

531.25 (3) experience a sudden closure of their current living arrangement;

531.26 (4) require protection from confirmed abuse, neglect, or exploitation;

531.27 (5) experience a sudden change in need that can no longer be met through state plan

531.28 services or other funding resources alone; or

531.29 (6) meet other priorities established by the department.

531.30 (c) When allocating new enrollment resources to lead agencies, the commissioner must

531.31 take into consideration the number of individuals waiting who meet statewide priorities and

532.1 the lead agencies' current use of waiver funds and existing service options. The commissioner

532.2 has the authority to transfer funds between counties, groups of counties, and tribes to

532.3 accommodate statewide priorities and resource needs while accounting for a necessary base

532.4 level reserve amount for each county, group of counties, and tribe.

532.5 Sec. 12. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision

532.6 to read:

532.7 Subd. 7. **Regional quality councils and systems improvement.** The commissioner of

532.8 human services shall maintain the regional quality councils initially established under

532.9 Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils

532.10 shall:

532.11 (1) support efforts and initiatives that drive overall systems and social change to promote

532.12 inclusion of people who have disabilities in the state of Minnesota;

532.13 (2) improve person-centered outcomes in disability services; and

532.14 (3) identify or enhance quality of life indicators for people who have disabilities.

532.15 Sec. 13. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision

532.16 to read:

532.17 Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of

532.18 key stakeholders including, but not limited to:

532.19 (1) individuals who have disabilities;

532.20 (2) family members of people who have disabilities;

532.21 (3) disability service providers;

532.22 (4) disability advocacy groups;

532.23 (5) lead agency staff; and

532.24 (6) staff of state agencies with jurisdiction over special education and disability services.

456.8 Sec. 17. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision

456.9 to read:

456.10 Subd. 7. **Regional quality councils and systems improvement.** The commissioner of

456.11 human services shall maintain the regional quality councils initially established under

456.12 Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils

456.13 shall:

456.14 (1) support efforts and initiatives that drive overall systems and social change to promote

456.15 inclusion of people who have disabilities in the state of Minnesota;

456.16 (2) improve person-centered outcomes in disability services; and

456.17 (3) identify or enhance quality of life indicators for people who have disabilities.

456.18 Sec. 18. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision

456.19 to read:

456.20 Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of

456.21 key stakeholders including, but not limited to:

456.22 (1) individuals who have disabilities;

456.23 (2) family members of people who have disabilities;

456.24 (3) disability service providers;

456.25 (4) disability advocacy groups;

456.26 (5) lead agency staff; and

456.27 (6) staff of state agencies with jurisdiction over special education and disability services.

532.25 (b) Membership in a regional quality council must be representative of the communities
532.26 in which the council operates, with an emphasis on individuals with lived experience from
532.27 diverse racial and cultural backgrounds.

532.28 (c) Each regional quality council may hire staff to perform the duties assigned in
532.29 subdivision 9.

533.1 Sec. 14. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
533.2 to read:

533.3 Subd. 9. **Duties.** (a) Each regional quality council shall:

533.4 (1) identify issues and barriers that impede Minnesotans who have disabilities from
533.5 optimizing choice of home and community-based services;

533.6 (2) promote informed decision making, autonomy, and self-direction;

533.7 (3) analyze and review quality outcomes and critical incident data, and immediately
533.8 report incidents of life safety concerns to the Department of Human Services Licensing
533.9 Division;

533.10 (4) inform a comprehensive system for effective incident reporting, investigation, analysis,
533.11 and follow-up;

533.12 (5) collaborate on projects and initiatives to advance priorities shared with state agencies,
533.13 lead agencies, educational institutions, advocacy organizations, community partners, and
533.14 other entities engaged in disability service improvements;

533.15 (6) establish partnerships and working relationships with individuals and groups in the
533.16 regions;

533.17 (7) identify and implement regional and statewide quality improvement projects;

533.18 (8) transform systems and drive social change in alignment with the disability rights and
533.19 disability justice movements identified by leaders who have disabilities;

533.20 (9) provide information and training programs for persons who have disabilities and
533.21 their families and legal representatives on formal and informal support options and quality
533.22 expectations;

533.23 (10) make recommendations to state agencies and other key decision-makers regarding
533.24 disability services and supports;

533.25 (11) submit every two years a report to committees with jurisdiction over disability
533.26 services on the status, outcomes, improvement priorities, and activities in the region;

533.27 (12) support people by advocating to resolve complaints between the counties, providers,
533.28 persons receiving services, and their families and legal representatives; and

456.28 (b) Membership in a regional quality council must be representative of the communities
456.29 in which the council operates, with an emphasis on individuals with lived experience from
456.30 diverse racial and cultural backgrounds.

457.1 (c) Each regional quality council may hire staff to perform the duties assigned in
457.2 subdivision 9.

457.3 Sec. 19. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
457.4 to read:

457.5 Subd. 9. **Duties.** (a) Each regional quality council shall:

457.6 (1) identify issues and barriers that impede Minnesotans who have disabilities from
457.7 optimizing choice of home and community-based services;

457.8 (2) promote informed decision making, autonomy, and self-direction;

457.9 (3) analyze and review quality outcomes and critical incident data, and immediately
457.10 report incidents of life safety concerns to the Department of Human Services Licensing
457.11 Division;

457.12 (4) inform a comprehensive system for effective incident reporting, investigation, analysis,
457.13 and follow-up;

457.14 (5) collaborate on projects and initiatives to advance priorities shared with state agencies,
457.15 lead agencies, educational institutions, advocacy organizations, community partners, and
457.16 other entities engaged in disability service improvements;

457.17 (6) establish partnerships and working relationships with individuals and groups in the
457.18 regions;

457.19 (7) identify and implement regional and statewide quality improvement projects;

457.20 (8) transform systems and drive social change in alignment with the disability rights and
457.21 disability justice movements identified by leaders who have disabilities;

457.22 (9) provide information and training programs for persons who have disabilities and
457.23 their families and legal representatives on formal and informal support options and quality
457.24 expectations;

457.25 (10) make recommendations to state agencies and other key decision-makers regarding
457.26 disability services and supports;

457.27 (11) submit every two years a report to legislative committees with jurisdiction over
457.28 disability services on the status, outcomes, improvement priorities, and activities in the
457.29 region;

457.30 (12) support people by advocating to resolve complaints between the counties, providers,
457.31 persons receiving services, and their families and legal representatives; and

533.29 (13) recruit, train, and assign duties to regional quality council teams, including council
533.30 members, interns, and volunteers, taking into account the skills necessary for the team
533.31 members to be successful in this work.

534.1 (b) Each regional quality council may engage in quality improvement initiatives related
534.2 to but not limited to:

534.3 (1) the home and community-based services waiver programs for persons with
534.4 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
534.5 including brain injuries and services for those persons who qualify for nursing facility level
534.6 of care or hospital facility level of care and any other services licensed under chapter 245D;

534.7 (2) home care services under section 256B.0651;

534.8 (3) family support grants under section 252.32;

534.9 (4) consumer support grants under section 256.476;

534.10 (5) semi-independent living services under section 252.275; and

534.11 (6) services provided through an intermediate care facility for persons with developmental
534.12 disabilities.

534.13 (c) Each regional quality council's work must be informed and directed by the needs
534.14 and desires of persons who have disabilities in the region in which the council operates.

534.15 Sec. 15. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
534.16 to read:

534.17 Subd. 10. **Compensation.** (a) A member of a regional quality council who does not
534.18 receive a salary or wages from an employer may be paid a per diem and reimbursed for
534.19 expenses related to the member's participation in efforts and initiatives described in
534.20 subdivision 9 in the same manner and in an amount not to exceed the amount authorized
534.21 by the commissioner's plan adopted under section 43A.18, subdivision 2.

534.22 (b) Regional quality councils may charge fees for their services.

458.1 (13) recruit, train, and assign duties to regional quality council teams, including council
458.2 members, interns, and volunteers, taking into account the skills necessary for the team
458.3 members to be successful in this work.

458.4 (b) Each regional quality council may engage in quality improvement initiatives related
458.5 to, but not limited to:

458.6 (1) the home and community-based services waiver programs for persons with
458.7 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
458.8 including brain injuries and services for those persons who qualify for nursing facility level
458.9 of care or hospital facility level of care and any other services licensed under chapter 245D;

458.10 (2) home care services under section 256B.0651;

458.11 (3) family support grants under section 252.32;

458.12 (4) consumer support grants under section 256.476;

458.13 (5) semi-independent living services under section 252.275; and

458.14 (6) services provided through an intermediate care facility for persons with developmental
458.15 disabilities.

458.16 (c) Each regional quality council's work must be informed and directed by the needs
458.17 and desires of persons who have disabilities in the region in which the council operates.

458.18 Sec. 20. Minnesota Statutes 2020, section 256B.097, is amended by adding a subdivision
458.19 to read:

458.20 Subd. 10. **Compensation.** (a) A member of a regional quality council who does not
458.21 receive a salary or wages from an employer may be paid a per diem and reimbursed for
458.22 expenses related to the member's participation in efforts and initiatives described in
458.23 subdivision 9 in the same manner and in an amount not to exceed the amount authorized
458.24 by the commissioner's plan adopted under section 43A.18, subdivision 2.

458.25 (b) Regional quality councils may charge fees for their services.

458.26 Sec. 21. Minnesota Statutes 2020, section 256B.19, subdivision 1, is amended to read:

458.27 Subdivision 1. **Division of cost.** The state and county share of medical assistance costs
458.28 not paid by federal funds shall be as follows:

459.1 (1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for
459.2 the cost of placement of severely emotionally disturbed children in regional treatment
459.3 centers;

459.4 (2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for
459.5 the costs of nursing facility placements of persons with disabilities under the age of 65 that
459.6 have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to
459.7 placements in facilities not certified to participate in medical assistance;

459.8 (3) beginning July 1, 2004, 90 percent state funds and ten percent county funds for the
459.9 costs of placements that have exceeded 90 days in intermediate care facilities for persons
459.10 with developmental disabilities that have seven or more beds. This provision includes
459.11 pass-through payments made under section 256B.5015; ~~and~~

459.12 (4) beginning July 1, 2004, when state funds are used to pay for a nursing facility
459.13 placement due to the facility's status as an institution for mental diseases (IMD), the county
459.14 shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause
459.15 is subject to chapter 256G;

459.16 (5) for any individual who has not been continuously receiving services in an intermediate
459.17 care facility for persons with developmental disabilities since December 31, 2021, 90 percent
459.18 state funds and ten percent county funds for the costs of any placement of an individual 18
459.19 years of age or older and under 27 years of age exceeding 90 days in any intermediate care
459.20 facility for persons with developmental disabilities. This provision includes pass-through
459.21 payments made under section 256B.5015. This provision is not in addition to the division
459.22 of costs under clause (3). This provision continues to apply to an individual after the
459.23 individual reaches the age of 27 and until the individual transitions to a community setting;
459.24 and

459.25 (6) for any individual who has not been continuously receiving residential support
459.26 services since December 31, 2021, 90 percent state funds and ten percent county funds for
459.27 the costs of residential support services when authorized for an individual 18 years of age
459.28 or older and under 27 years of age. This provision continues to apply to an individual after
459.29 the individual reaches the age of 27 and until the individual no longer receives residential
459.30 support services. For the purposes of this clause, "residential support services" means the
459.31 following residential support services reimbursed under section 256B.4914: community
459.32 residential services, customized living services, and 24-hour customized living services.

459.33 For counties that participate in a Medicaid demonstration project under sections 256B.69
459.34 and 256B.71, the division of the nonfederal share of medical assistance expenses for
460.1 payments made to prepaid health plans or for payments made to health maintenance
460.2 organizations in the form of prepaid capitation payments, this division of medical assistance
460.3 expenses shall be 95 percent by the state and five percent by the county of financial
460.4 responsibility.

460.5 In counties where prepaid health plans are under contract to the commissioner to provide
460.6 services to medical assistance recipients, the cost of court ordered treatment ordered without
460.7 consulting the prepaid health plan that does not include diagnostic evaluation,
460.8 recommendation, and referral for treatment by the prepaid health plan is the responsibility
460.9 of the county of financial responsibility.

460.10 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
460.11 whichever is later. The commissioner of human services shall inform the revisor of statutes
460.12 when federal approval is obtained.

534.23 Sec. 16. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision
534.24 to read:

534.25 Subd. 3c. **Contact information for consumer surveys for nursing facilities and home**
534.26 **and community-based services.** For purposes of conducting the consumer surveys under
534.27 subdivisions 3 and 3a, the commissioner may request contact information of clients and
534.28 associated key representatives. Providers must furnish the contact information available to
534.29 the provider.

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

535.1 Sec. 17. Minnesota Statutes 2020, section 256B.439, is amended by adding a subdivision
535.2 to read:

535.3 Subd. 3d. **Resident experience survey and family survey for assisted living**
535.4 **facilities.** The commissioner shall develop and administer a resident experience survey for
535.5 assisted living facility residents and a family survey for families of assisted living facility
535.6 residents. Money appropriated to the commissioner to administer the resident experience
535.7 survey and family survey is available in either fiscal year of the biennium in which it is
535.8 appropriated.

535.9 Sec. 18. Minnesota Statutes 2020, section 256B.49, subdivision 11, is amended to read:

535.10 Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and
535.11 community-based service waivers, as authorized under section 1915(c) of the federal Social
535.12 Security Act to serve persons under the age of 65 who are determined to require the level
535.13 of care provided in a nursing home and persons who require the level of care provided in a
535.14 hospital. The commissioner shall apply for the home and community-based waivers in order
535.15 to:

535.16 (1) promote the support of persons with disabilities in the most integrated settings;
535.17 (2) expand the availability of services for persons who are eligible for medical assistance;
535.18 (3) promote cost-effective options to institutional care; and
535.19 (4) obtain federal financial participation.

535.20 (b) The provision of ~~waivered~~ waiver services to medical assistance recipients with
535.21 disabilities shall comply with the requirements outlined in the federally approved applications
535.22 for home and community-based services and subsequent amendments, including provision
535.23 of services according to a service plan designed to meet the needs of the individual. For
535.24 purposes of this section, the approved home and community-based application is considered
535.25 the necessary federal requirement.

535.26 (c) The commissioner shall provide interested persons serving on agency advisory
535.27 committees, task forces, the Centers for Independent Living, and others who request to be
535.28 on a list to receive, notice of, and an opportunity to comment on, at least 30 days before

535.29 any effective dates, (1) any substantive changes to the state's disability services program
535.30 manual, or (2) changes or amendments to the federally approved applications for home and
535.31 community-based waivers, prior to their submission to the federal Centers for Medicare
535.32 and Medicaid Services.

536.1 (d) The commissioner shall seek approval, as authorized under section 1915(c) of the
536.2 federal Social Security Act, to allow medical assistance eligibility under this section for
536.3 children under age 21 without deeming of parental income or assets.

536.4 (e) The commissioner shall seek approval, as authorized under section 1915(c) of the
536.5 Social Act, to allow medical assistance eligibility under this section for individuals under
536.6 age 65 without deeming the spouse's income or assets.

536.7 (f) The commissioner shall comply with the requirements in the federally approved
536.8 transition plan for the home and community-based services waivers authorized under this
536.9 section.

536.10 (g) The commissioner shall seek federal approval to allow for the reconfiguration of the
536.11 1915(c) home and community-based waivers in this section, as authorized under section
536.12 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

536.13 (h) The commissioner shall seek federal approval for the 1915(c) home and
536.14 community-based waivers in this section, as authorized under section 1915(c) of the federal
536.15 Social Security Act, to implement an individual resource allocation methodology.

536.16 **EFFECTIVE DATE.** This section is effective January 1, 2023, or 90 days after federal
536.17 approval, whichever is later. The commissioner of human services shall notify the revisor
536.18 of statutes when federal approval is obtained.

536.19 Sec. 19. Minnesota Statutes 2020, section 256B.49, subdivision 11a, is amended to read:

536.20 Subd. 11a. ~~Waived Waiver services statewide priorities.~~ (a) The commissioner shall
536.21 establish statewide priorities for individuals on the waiting list for community alternative
536.22 care, community access for disability inclusion, and brain injury waiver services, as of
536.23 January 1, 2010. The statewide priorities must include, but are not limited to, individuals
536.24 who continue to have a need for waiver services after they have maximized the use of state
536.25 plan services and other funding resources, including natural supports, prior to accessing
536.26 waiver services, and who meet at least one of the following criteria:

536.27 (1) no longer require the intensity of services provided where they are currently living;
536.28 or

536.29 (2) make a request to move from an institutional setting.

536.30 (b) After the priorities in paragraph (a) are met, priority must also be given to individuals
536.31 who meet at least one of the following criteria:

537.1 (1) have unstable living situations due to the age, incapacity, or sudden loss of the primary
537.2 caregivers;

537.3 (2) are moving from an institution due to bed closures;

537.4 (3) experience a sudden closure of their current living arrangement;

537.5 (4) require protection from confirmed abuse, neglect, or exploitation;

537.6 (5) experience a sudden change in need that can no longer be met through state plan
537.7 services or other funding resources alone; or

537.8 (6) meet other priorities established by the department.

537.9 (c) When allocating new enrollment resources to lead agencies, the commissioner must
537.10 take into consideration the number of individuals waiting who meet statewide priorities ~~and~~
537.11 ~~the lead agencies' current use of waiver funds and existing service options. The commissioner~~
537.12 ~~has the authority to transfer funds between counties, groups of counties, and tribes to~~
537.13 ~~accommodate statewide priorities and resource needs while accounting for a necessary base~~
537.14 ~~level reserve amount for each county, group of counties, and tribe.~~

537.15 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
537.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
537.17 when federal approval is obtained.

537.18 Sec. 20. Minnesota Statutes 2020, section 256B.49, subdivision 17, is amended to read:

537.19 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the
537.20 average per capita expenditures estimated in any fiscal year for home and community-based
537.21 waiver recipients does not exceed the average per capita expenditures that would have been
537.22 made to provide institutional services for recipients in the absence of the waiver.

537.23 ~~(b) The commissioner shall implement on January 1, 2002, one or more aggregate,~~
537.24 ~~need-based methods for allocating to local agencies the home and community-based waived~~
537.25 ~~service resources available to support recipients with disabilities in need of the level of care~~
537.26 ~~provided in a nursing facility or a hospital. The commissioner shall allocate resources to~~
537.27 ~~single counties and county partnerships in a manner that reflects consideration of:~~

537.28 ~~(1) an incentive-based payment process for achieving outcomes;~~

537.29 ~~(2) the need for a state-level risk pool;~~

537.30 ~~(3) the need for retention of management responsibility at the state agency level; and~~

537.31 ~~(4) a phase-in strategy as appropriate.~~

538.1 (e) ~~Until the allocation methods described in paragraph (b) are implemented, the annual~~
538.2 ~~allowable reimbursement level of home and community-based waiver services shall be the~~
538.3 ~~greater of:~~

538.4 ~~(1) the statewide average payment amount which the recipient is assigned under the~~
538.5 ~~waiver reimbursement system in place on June 30, 2001, modified by the percentage of any~~
538.6 ~~provider rate increase appropriated for home and community-based services; or~~

538.7 ~~(2) an amount approved by the commissioner based on the recipient's extraordinary~~
538.8 ~~needs that cannot be met within the current allowable reimbursement level. The increased~~
538.9 ~~reimbursement level must be necessary to allow the recipient to be discharged from an~~
538.10 ~~institution or to prevent imminent placement in an institution. The additional reimbursement~~
538.11 ~~may be used to secure environmental modifications; assistive technology and equipment;~~
538.12 ~~and increased costs for supervision, training, and support services necessary to address the~~
538.13 ~~recipient's extraordinary needs. The commissioner may approve an increased reimbursement~~
538.14 ~~level for up to one year of the recipient's relocation from an institution or up to six months~~
538.15 ~~of a determination that a current waiver recipient is at imminent risk of being placed in an~~
538.16 ~~institution.~~

538.17 ~~(d)~~ (b) Beginning July 1, 2001, medically necessary home care nursing services will be
538.18 authorized under this section as complex and regular care according to sections 256B.0651
538.19 to 256B.0654 and 256B.0659. The rate established by the commissioner for registered nurse
538.20 or licensed practical nurse services under any home and community-based waiver as of
538.21 January 1, 2001, shall not be reduced.

538.22 ~~(e)~~ (c) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
538.23 legislature adopts a rate reduction that impacts payment to providers of adult foster care
538.24 services, the commissioner may issue adult foster care licenses that permit a capacity of
538.25 five adults. The application for a five-bed license must meet the requirements of section
538.26 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services,
538.27 the county must negotiate a revised per diem rate for room and board and waiver services
538.28 that reflects the legislated rate reduction and results in an overall average per diem reduction
538.29 for all foster care recipients in that home. The revised per diem must allow the provider to
538.30 maintain, as much as possible, the level of services or enhanced services provided in the
538.31 residence, while mitigating the losses of the legislated rate reduction.

538.32 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
538.33 whichever is later. The commissioner of human services shall notify the revisor of statutes
538.34 when federal approval is obtained.

460.13 Sec. 22. Minnesota Statutes 2020, section 256B.49, subdivision 23, is amended to read:

460.14 Subd. 23. **Community-living settings.** (a) For the purposes of this chapter,
460.15 "community-living settings" means a single-family home or multifamily dwelling unit where
460.16 a service recipient or a service recipient's family owns or rents, and maintains control over
460.17 the individual unit as demonstrated by a lease agreement. Community-living settings does
460.18 not include a home or dwelling unit that the service provider owns, operates, or leases or
460.19 in which the service provider has a direct or indirect financial interest.

460.20 (b) To ensure a service recipient or the service recipient's family maintains control over
460.21 the home or dwelling unit, community-living settings are subject to the following
460.22 requirements;

460.23 (1) service recipients must not be required to receive services or share services;

460.24 (2) service recipients must not be required to have a disability or specific diagnosis to
460.25 live in the community-living setting;

460.26 (3) service recipients may hire service providers of their choice;

460.27 (4) service recipients may choose whether to share their household and with whom;

460.28 (5) the home or multifamily dwelling unit must include living, sleeping, bathing, and
460.29 cooking areas;

460.30 (6) service recipients must have lockable access and egress;

460.31 (7) service recipients must be free to receive visitors and leave the settings at times and
460.32 for durations of their own choosing;

461.1 (8) leases must comply with chapter 504B;

461.2 (9) landlords must not charge different rents to tenants who are receiving home and
461.3 community-based services; and

461.4 (10) access to the greater community must be easily facilitated based on the service
461.5 recipient's needs and preferences.

461.6 (c) Nothing in this section prohibits a service recipient from having another person or
461.7 entity not affiliated with the service provider cosign a lease. Nothing in this section prohibits
461.8 a service recipient, during any period in which a service provider has cosigned the service
461.9 recipient's lease, from modifying services with an existing cosigning service provider and,
461.10 subject to the approval of the landlord, maintaining a lease cosigned by the service provider.
461.11 Nothing in this section prohibits a service recipient, during any period in which a service
461.12 provider has cosigned the service recipient's lease, from terminating services with the
461.13 cosigning service provider, receiving services from a new service provider, and, subject to
461.14 the approval of the landlord, maintaining a lease cosigned by the new service provider.

461.15 (d) A lease cosigned by a service provider meets the requirements of paragraph (a) if
461.16 the service recipient and service provider develop and implement a transition plan which
461.17 must provide that, within two years of cosigning the initial lease, the service provider shall
461.18 transfer the lease to the service recipient and other cosigners, if any.

461.19 (e) In the event the landlord has not approved the transfer of the lease within two years
461.20 of the service provider cosigning the initial lease, the service provider must submit a
461.21 time-limited extension request to the commissioner of human services to continue the
461.22 cosigned lease arrangement. The extension request must include:

539.1 Sec. 21. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision
539.2 to read:

539.3 Subd. 28. **Customized living moratorium for brain injury and community access**
539.4 **for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2,
539.5 paragraph (a), clause (23), the commissioner shall not enroll new customized living settings
539.6 serving four or fewer people in a single-family home to deliver customized living services
539.7 as defined under the brain injury or community access for disability inclusion waiver plans
539.8 under section 256B.49 to prevent new developments of customized living settings that
539.9 otherwise meet the residential program definition under section 245A.02, subdivision 14.

539.10 (b) The commissioner may approve an exception to paragraph (a) when:

539.11 (1) a customized living setting with a change in ownership at the same address is in
539.12 existence and operational on or before June 30, 2021; and

539.13 (2) a customized living setting is serving four or fewer people in a multiple-family
539.14 dwelling if each person has a personal self-contained living unit that contains living, sleeping,
539.15 eating, cooking, and bathroom areas.

461.23 (1) the reason the landlord denied the transfer;
461.24 (2) the plan to overcome the denial to transfer the lease;
461.25 (3) the length of time needed to successfully transfer the lease, not to exceed an additional
461.26 two years;

461.27 (4) a description of how the transition plan was followed, what occurred that led to the
461.28 landlord denying the transfer, and what changes in circumstances or condition, if any, the
461.29 service recipient experienced; and

461.30 (5) a revised transition plan to transfer the cosigned lease between the service provider
461.31 and the service recipient to the service recipient.

462.1 The commissioner must approve an extension within sufficient time to ensure the continued
462.2 occupancy by the service recipient.

462.3 (f) In the event that a landlord has not approved a transfer of the lease within the timelines
462.4 of any approved time-limited extension request, a service provider must submit another
462.5 time-limited extension request to the commissioner of human services to continue a cosigned
462.6 lease arrangement. A time-limited extension request submitted under this paragraph must
462.7 include the same information required for an initial time-limited extension request under
462.8 paragraph (e). The commissioner must approve of an extension within sufficient time to
462.9 ensure continued occupancy by the service recipient.

462.10 Sec. 23. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision
462.11 to read:

462.12 Subd. 28. **Customized living moratorium for brain injury and community access**
462.13 **for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2,
462.14 paragraph (a), clause (23), to prevent new development of customized living settings that
462.15 otherwise meet the residential program definition under section 245A.02, subdivision 14,
462.16 the commissioner shall not enroll new customized living settings serving four or fewer
462.17 people in a single-family home to deliver customized living services as defined under the
462.18 brain injury or community access for disability inclusion waiver plans under section 256B.49.

462.19 (b) The commissioner may approve an exception to paragraph (a) when an existing
462.20 customized living setting changes ownership at the same address.

539.16 (c) Customized living settings operational on or before June 30, 2021, are considered
539.17 existing customized living settings.

539.18 (d) For any new customized living settings operational on or after July 1, 2021, serving
539.19 four or fewer people in a single-family home to deliver customized living services as defined
539.20 in paragraph (a), the authorizing lead agency is financially responsible for all home and
539.21 community-based service payments in the setting.

539.22 (e) For purposes of this subdivision, "operational" means customized living services are
539.23 authorized and delivered to a person on or before June 30, 2021, in the customized living
539.24 setting.

539.25 **EFFECTIVE DATE.** This section is effective July 1, 2021. This section applies only
539.26 to customized living services as defined under the brain injury or community access for
539.27 disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

462.21 (c) Customized living settings operational on or before June 30, 2021, are considered
462.22 existing customized living settings.

462.23 (d) For any new customized living settings serving four or fewer people in a single-family
462.24 home to deliver customized living services as defined in paragraph (a) and that was not
462.25 operational on or before June 30, 2021, the authorizing lead agency is financially responsible
462.26 for all home and community-based service payments in the setting.

462.27 (e) For purposes of this subdivision, "operational" means customized living services are
462.28 authorized and delivered to a person in the customized living setting.

462.29 **EFFECTIVE DATE.** This section is effective July 1, 2021. This section applies only
462.30 to customized living services as defined under the brain injury or community access for
462.31 disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

463.1 Sec. 24. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
463.2 to read:

463.3 Subd. 1a. **Definitions.** (a) For purposes of this section, the following terms have the
463.4 meanings given.

463.5 (b) "Informed choice" means a choice that adults who have disabilities and, with support
463.6 from their families or legal representatives, that children who have disabilities make regarding
463.7 services and supports that best meets the adult's or child's needs and preferences. Before
463.8 making an informed choice, an individual who has disabilities must be provided, in an
463.9 accessible format and manner that meets the individual's needs, the tools, information, and
463.10 opportunities the individual requests or requires to understand all of the individual's options.

463.11 (c) "HCBS" means home and community-based services covered under this chapter by
463.12 the medical assistance state plan, and the home and community-based waiver services
463.13 covered under sections 256B.092 and 256B.49.

463.14 Sec. 25. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
463.15 to read:

463.16 Subd. 2a. **Informed choice policy.** It is the policy of this state that all adults who have
463.17 disabilities and, with support from their families or legal representatives, all children who
463.18 have disabilities:

463.19 (1) can make informed choices to select and utilize disability services and supports; and

463.20 (2) will be offered an informed decision-making process sufficient to make informed
463.21 choices.

- 463.22 Sec. 26. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
463.23 to read:
- 463.24 Subd. 3a. **Informed decision making.** (a) The commissioner of human services and
463.25 lead agencies shall ensure that:
- 463.26 (1) disability services support the presumption that adults who have disabilities and,
463.27 with support from their families or legal representatives, children who have disabilities can
463.28 make informed choices;
- 463.29 (2) all adults who have disabilities and are accessing HCBS and all families of children
463.30 who have disabilities and are accessing HCBS are provided an informed decision-making
463.31 process satisfying the requirements of paragraph (b);
- 464.1 (3) all adults who have disabilities and are accessing HCBS and all families of children
464.2 who have disabilities and are accessing HCBS are provided the opportunity to revisit or
464.3 change any decision or choice at any time of the adult's or family's choosing; and
- 464.4 (4) services or supports necessary to accomplish each step of an informed
464.5 decision-making process or to make an informed choice to utilize disability services are
464.6 authorized and implemented within a reasonable time frame for individuals accessing HCBS.
- 464.7 (b) The commissioner of human services must develop and ensure compliance with an
464.8 informed decision-making standard that provides accessible, correct, and complete
464.9 information to help an individual accessing HCBS make an informed choice. This information
464.10 must be accessible and understandable to the person so that the person can demonstrate
464.11 understanding of the options. Any written information provided in the process must be
464.12 accessible and the process must be experiential whenever possible. The process must also
464.13 consider and offer to the person, in a person-centered manner, the following:
- 464.14 (1) reasonable accommodations as needed or requested by the person to fully participate
464.15 in the informed decision-making process and acquire the information necessary to make an
464.16 informed choice;
- 464.17 (2) discussion of the person's own preferences, abilities, goals, and objectives;
- 464.18 (3) identification of the person's cultural needs and access to culturally responsive services
464.19 and providers;
- 464.20 (4) information about the benefits of inclusive and individualized services and supports;
- 464.21 (5) presentation and discussion of all options with the person;
- 464.22 (6) documentation, in a manner prescribed by the commissioner, of each option discussed;
- 464.23 (7) exploration and development of new or other options;

464.24 (8) facilitation of opportunities to visit alternative locations or to engage in experiences
464.25 to understand how any service option might work for the person;

464.26 (9) opportunities to meet with other individuals with disabilities who live, work, and
464.27 receive services different from the person's own services;

464.28 (10) development of a transition plan, when needed or requested by the person, to
464.29 facilitate the choice to move from one service type or setting to another, and authorization
464.30 of the services and supports necessary to effectuate the plan;

465.1 (11) identification of any barriers to assisting or implementing the person's informed
465.2 choice and authorization of the services and supports necessary to overcome those barriers;
465.3 and

465.4 (12) ample time and timely opportunity to consider available options before the individual
465.5 makes a final choice or changes a choice.

465.6 (c) The commissioner shall ensure that individuals accessing HCBS have access to an
465.7 informed decision-making process at least annually by:

465.8 (1) updating informed choice protocols for HCBS to reflect the informed choice definition
465.9 in subdivision 1a, paragraph (b), and the informed decision-making process outlined in
465.10 paragraph (b);

465.11 (2) developing a survey designed for individuals accessing HCBS to assess their
465.12 experience with informed choice and the informed decision-making process, including how
465.13 frequently it is offered and how well it meets the standard in paragraph (b). The survey shall
465.14 be administered and results used to determine the quality and frequency of informed choice
465.15 and informed decision making consistent with this section. The commissioner shall utilize
465.16 survey results to increase the frequency and quality of informed decision making and
465.17 informed choice as experienced by individuals accessing HCBS;

465.18 (3) creating option for interested persons to file incident reports regarding an access to
465.19 and the quality of informed choice and informed decision making experienced by an
465.20 individual accessing HCBS, and implementing appropriate processes upon receipt of the
465.21 reports;

465.22 (4) developing and implementing a curriculum and training plan to ensure all lead agency
465.23 assessors and case managers have the knowledge and skills to comply with this section.
465.24 Training and competency evaluations must be completed annually by all staff responsible
465.25 for case management as described in section 256B.092, subdivision 1a, paragraph (f), and
465.26 section 256B.49, subdivision 13, paragraph (e); and

465.27 (5) mandating informed choice training for lead agency staff who support individuals
465.28 accessing HCBS.

465.29 Sec. 27. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
465.30 to read:

465.31 Subd. 4a. **Informed choice in employment policy.** It is the policy of this state that
465.32 working-age individuals who have disabilities:

466.1 (1) can work and achieve competitive integrated employment with appropriate services
466.2 and supports, as needed;

466.3 (2) make informed choices about their postsecondary education, work, and career goals;
466.4 and

466.5 (3) will be offered the opportunity to make an informed choice, at least annually, to
466.6 pursue postsecondary education or to work and earn a competitive wage.

466.7 Sec. 28. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
466.8 to read:

466.9 Subd. 5a. **Informed choice in employment implementation.** (a) The commissioner of
466.10 human services and lead agencies shall ensure that disability services align with the
466.11 employment first policy adopted by the Olmstead subcabinet on September 29, 2014, or
466.12 successor policies.

466.13 (b) The commissioner and lead agencies shall implement the provisions of subdivision
466.14 3a, paragraph (c), and take other appropriate actions to ensure that all working-age individuals
466.15 who have disabilities and are accessing HCBS are offered an informed decision-making
466.16 process that will help them make an informed choice about postsecondary education offering
466.17 meaningful credentials; and about working and earning, with appropriate services and
466.18 supports, a competitive wage in work or a career that the individual chooses before being
466.19 offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph
466.20 (c), clause (4), or successor provisions.

466.21 Sec. 29. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
466.22 to read:

466.23 Subd. 7. **Informed choice in community living policy.** It is the policy of this state that
466.24 all adults who have disabilities:

466.25 (1) can live in the communities of the individual's choosing with appropriate services
466.26 and supports as needed; and

466.27 (2) have the right, at least annually, to make an informed decision-making process that
466.28 can help them make an informed choice to live outside of a provider-controlled setting.

467.1 Sec. 30. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
467.2 to read:

467.3 Subd. 8. **Informed choice in community living implementation.** (a) The commissioner
467.4 of human services and lead agencies shall ensure that disability services support the

467.5 presumption that all adults who have disabilities can and want to live in the communities
467.6 of the individual's choosing with services and supports as needed.

467.7 (b) The commissioner and lead agencies shall implement the provisions of subdivision
467.8 3a, paragraph (c), and take any appropriate action to ensure that all adults who have
467.9 disabilities and are accessing HCBS are offered, after an informed decision-making process
467.10 and during a person-centered planning process, the services and supports the individual
467.11 needs to live as the individual chooses, including in a non-provider-controlled setting.
467.12 Provider-controlled settings include customized living services provided in a single-family
467.13 home or residential supports and services as defined in section 245D.03, subdivision 1,
467.14 paragraph (c), clause (3), or successor provisions, unless the residential services and supports
467.15 are provided in a family adult foster care residence under a shared living option as described
467.16 in Laws 2013, chapter 108, article 7, section 62.

467.17 Sec. 31. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
467.18 to read:

467.19 Subd. 9. **Informed choice in self-direction policy.** It is the policy of this state that adults
467.20 who have disabilities and families of children who have disabilities:

467.21 (1) can direct the adult's or child's needed services and supports; and

467.22 (2) have the right to make an informed choice to self-direct the adult's or child's services
467.23 and supports before being offered options that do not allow the adult or family to self-direct
467.24 the adult's or child's services and supports.

467.25 Sec. 32. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
467.26 to read:

467.27 Subd. 10. **Informed choice in self-direction implementation.** (a) The commissioner
467.28 of human services and lead agencies shall ensure that disability services support the
467.29 presumption that adults who have disabilities and families of children who have disabilities
467.30 can direct all of the adult's or child's services and supports, including control over the funding
467.31 of the adult's or child's services and supports.

468.1 (b) The commissioner and lead agencies shall implement the provisions of subdivision
468.2 3a, paragraph (c), and take any other appropriate actions to ensure that at intervals described
468.3 in paragraph (c), adults who have disabilities and are accessing HCBS and families of
468.4 children who have disabilities and are accessing HCBS are offered, after an informed
468.5 decision-making process and during a person-centered planning process, the option to direct
468.6 the adult's or child's services and supports, including the option to have control over the
468.7 funding of the adult's or child's services and supports.

468.8 (c) The commissioner or lead agency shall offer adults who have disabilities and families
468.9 of children who have disabilities the options described in paragraph (b) at least annually
468.10 during regularly scheduled planning meetings or more frequently when:

468.11 (1) the adults who have disabilities or families of children who have disabilities requests
468.12 or suggests the options described in paragraph (b) or when the adult or family expresses
468.13 dissatisfaction with services and supports that do not allow for self-direction;

468.14 (2) the family or a legal representative of the individual with disabilities requests or
468.15 suggests the options described in paragraph (b);

468.16 (3) any member of the individual's service planning team or expanded service planning
468.17 team requests or suggests the options described in paragraph (b); or

468.18 (4) self-directed services and supports could enhance the individual's independence or
468.19 quality of life.

468.20 Sec. 33. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
468.21 to read:

468.22 Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all
468.23 adults who have disabilities and children who have disabilities:

468.24 (1) can use assistive technology, remote supports, or a combination of both to enhance
468.25 the adult's or child's independence and quality of life; and

468.26 (2) have the right, at least annually, to make an informed choice about the adult's or
468.27 child's use of assistive technology and remote supports.

468.28 Sec. 34. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision
468.29 to read:

468.30 Subd. 12. **Informed choice in technology implementation.** (a) The commissioner of
468.31 human services and lead agencies shall ensure that disability services support the presumption
469.1 that adults who have disabilities and children who have disabilities can use or benefit from
469.2 assistive technology, remote supports, or both.

469.3 (b) The commissioner and lead agencies shall implement the provisions of subdivision
469.4 3a, paragraph (c), and take any other appropriate actions to ensure that at intervals described
469.5 in paragraph (c), adults who have disabilities and are accessing HCBS and families of
469.6 children who have disabilities and are accessing HCBS are offered, after an informed
469.7 decision-making process and during a person-centered planning process, the opportunity
469.8 to choose assistive technology, remote support, or both, to ensure equitable access.

469.9 (c) The commissioner or lead agency shall offer adults who have disabilities and families
469.10 of children who have disabilities the options described in paragraph (b) at least annually
469.11 during a regularly scheduled planning meeting or more frequently when:

469.12 (1) the adult who has disabilities or the family of a child who has disabilities requests
469.13 or suggests the options described in paragraph (b) or when the adult or family expresses
469.14 dissatisfaction with in-person services and supports;

469.15 (2) the family or a legal representative of the individual with disabilities requests or
469.16 suggests the options described in paragraph (b);

469.17 (3) any member of the individual's service planning team or expanded service planning
469.18 team requests or suggests the options described in paragraph (b); or

469.19 (4) assistive technology, remote supports, or both could enhance the individual's
469.20 independence or quality of life.

469.21 (d) The availability of assistive technology, remote supports, or both, shall not preclude
469.22 an individual with disabilities from accessing in-person supports and services, nor shall it
469.23 result in a denial of in-person supports and services.

469.24 Sec. 35. Minnesota Statutes 2020, section 256B.4914, subdivision 2, is amended to read:

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

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

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

469.31 (1) typical education needed for entry;

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

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

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

470.6 (e) "Customized living tool" means a methodology for setting service rates that delineates
470.7 and documents the amount of each component service included in a recipient's customized
470.8 living service plan.

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

470.12 (g) "Disability waiver rates system" means a statewide system that establishes rates that
470.13 are based on uniform processes and captures the individualized nature of waiver services
470.14 and recipient needs.

470.15 (h) "Individual staffing" means the time spent as a one-to-one interaction specific to an
470.16 individual recipient by staff to provide direct support and assistance with activities of daily
470.17 living, instrumental activities of daily living, and training to participants, and is based on
470.18 the requirements in each individual's coordinated service and support plan under section

- 470.19 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
470.20 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
470.21 needs must also be considered.
- 470.22 (i) "Lead agency" means a county, partnership of counties, or tribal agency charged with
470.23 administering waived services under sections 256B.092 and 256B.49.
- 470.24 (j) "Median" means the amount that divides distribution into two equal groups, one-half
470.25 above the median and one-half below the median.
- 470.26 (k) "Payment or rate" means reimbursement to an eligible provider for services provided
470.27 to a qualified individual based on an approved service authorization.
- 470.28 (l) "Rates management system" means a web-based software application that uses a
470.29 framework and component values, as determined by the commissioner, to establish service
470.30 rates.
- 470.31 (m) "Recipient" means a person receiving home and community-based services funded
470.32 under any of the disability waivers.
- 471.1 (n) "Shared staffing" means time spent by employees, not defined under paragraph (f),
471.2 providing or available to provide more than one individual with direct support and assistance
471.3 with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph
471.4 (b); instrumental activities of daily living as defined under section 256B.0659, subdivision
471.5 1, paragraph (i); ancillary activities needed to support individual services; and training to
471.6 participants, and is based on the requirements in each individual's coordinated service and
471.7 support plan under section 245D.02, subdivision 4b; any coordinated service and support
471.8 plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider
471.9 observation of an individual's service need. Total shared staffing hours are divided
471.10 proportionally by the number of individuals who receive the shared service provisions.
- 471.11 (o) "Staffing ratio" means the number of recipients a service provider employee supports
471.12 during a unit of service based on a uniform assessment tool, provider observation, case
471.13 history, and the recipient's services of choice, and not based on the staffing ratios under
471.14 section 245D.31.
- 471.15 (p) "Unit of service" means the following:
- 471.16 (1) for residential support services under subdivision 6, a unit of service is a day. Any
471.17 portion of any calendar day, within allowable Medicaid rules, where an individual spends
471.18 time in a residential setting is billable as a day;
- 471.19 (2) for day services under subdivision 7;
- 471.20 (i) for day training and habilitation services, a unit of service is either:
- 471.21 (A) a day unit of service is defined as six or more hours of time spent providing direct
471.22 services and transportation; or

539.28 Sec. 22. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

539.29 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
539.30 is established to determine staffing costs associated with providing services to individuals
539.31 receiving home and community-based services. For purposes of developing and calculating
539.32 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
540.1 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
540.2 the most recent edition of the Occupational Handbook must be used. The base wage index
540.3 must be calculated as follows:

540.4 (1) for residential direct care staff, the sum of:

540.5 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
540.6 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
540.7 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
540.8 code 21-1093); and

471.23 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
471.24 direct services and transportation; and

471.25 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
471.26 be used for fewer than six hours of time spent providing direct services and transportation;

471.27 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
471.28 day unit of service is six or more hours of time spent providing direct services;

471.29 (iii) for day support services, a unit of service is 15 minutes; and

471.30 (iv) for prevocational services, a unit of service is a day or 15 minutes. A day unit of
471.31 service is six or more hours of time spent providing direct service;

471.32 (3) for unit-based services with programming under subdivision 8:

472.1 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
472.2 rate is authorized, any portion of a calendar day where an individual receives services is
472.3 billable as a day; ~~and~~

472.4 (ii) for individualized home supports with training, a unit of service is a day or 15 minutes.
472.5 A day unit of service is six or more hours of time spent providing direct service; and

472.6 (iii) for all other services, a unit of service is 15 minutes; and

472.7 (4) for unit-based services without programming under subdivision 9, a unit of service
472.8 is 15 minutes.

472.9 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
472.10 whichever is later. The commissioner of human services shall notify the revisor of statutes
472.11 when federal approval is obtained.

472.12 Sec. 36. Minnesota Statutes 2020, section 256B.4914, subdivision 5, is amended to read:

472.13 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
472.14 is established to determine staffing costs associated with providing services to individuals
472.15 receiving home and community-based services. For purposes of developing and calculating
472.16 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
472.17 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
472.18 the most recent edition of the Occupational Handbook must be used. The base wage index
472.19 must be calculated as follows:

472.20 (1) for residential direct care staff, the sum of:

472.21 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
472.22 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC
472.23 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC
472.24 code 21-1093); and

540.9 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
540.10 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
540.11 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
540.12 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
540.13 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

540.14 (2) for adult day services, 70 percent of the median wage for nursing assistant (SOC
540.15 code 31-1014); and 30 percent of the median wage for personal care aide (SOC code
540.16 39-9021);

540.17 (3) for day services, day support services, and prevocational services, 20 percent of the
540.18 median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for
540.19 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
540.20 and human services aide (SOC code 21-1093);

540.21 (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
540.22 for large employers, ~~except in a family foster care setting, the wage is 36 percent of the~~
540.23 ~~minimum wage in Minnesota for large employers;~~

540.24 (5) for positive supports analyst staff, 100 percent of the median wage for mental health
540.25 counselors (SOC code 21-1014);

540.26 (6) for positive supports professional staff, 100 percent of the median wage for clinical
540.27 counseling and school psychologist (SOC code 19-3031);

540.28 (7) for positive supports specialist staff, 100 percent of the median wage for psychiatric
540.29 technicians (SOC code 29-2053);

540.30 (8) for supportive living services staff, 20 percent of the median wage for nursing assistant
540.31 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
540.32 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
540.33 21-1093);

541.1 (9) for housing access coordination staff, 100 percent of the median wage for community
541.2 and social services specialist (SOC code 21-1099);

541.3 (10) for in-home family support and individualized home supports with family training
541.4 staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of
541.5 the median wage for community social service specialist (SOC code 21-1099); 40 percent
541.6 of the median wage for social and human services aide (SOC code 21-1093); and ten percent
541.7 of the median wage for psychiatric technician (SOC code 29-2053);

541.8 (11) for individualized home supports with training services staff, 40 percent of the
541.9 median wage for community social service specialist (SOC code 21-1099); 50 percent of
541.10 the median wage for social and human services aide (SOC code 21-1093); and ten percent
541.11 of the median wage for psychiatric technician (SOC code 29-2053);

472.25 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
472.26 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
472.27 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
472.28 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
472.29 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

472.30 (2) for adult day services, 70 percent of the median wage for nursing assistant (SOC
472.31 code 31-1014); and 30 percent of the median wage for personal care aide (SOC code
472.32 39-9021);

473.1 (3) for day services, day support services, and prevocational services, 20 percent of the
473.2 median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for
473.3 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
473.4 and human services aide (SOC code 21-1093);

473.5 (4) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
473.6 for large employers, ~~except in a family foster care setting, the wage is 36 percent of the~~
473.7 ~~minimum wage in Minnesota for large employers;~~

473.8 (5) for positive supports analyst staff, 100 percent of the median wage for mental health
473.9 counselors (SOC code 21-1014);

473.10 (6) for positive supports professional staff, 100 percent of the median wage for clinical
473.11 counseling and school psychologist (SOC code 19-3031);

473.12 (7) for positive supports specialist staff, 100 percent of the median wage for psychiatric
473.13 technicians (SOC code 29-2053);

473.14 (8) for supportive living services staff, 20 percent of the median wage for nursing assistant
473.15 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
473.16 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
473.17 21-1093);

473.18 (9) for housing access coordination staff, 100 percent of the median wage for community
473.19 and social services specialist (SOC code 21-1099);

473.20 (10) for in-home family support and individualized home supports with family training
473.21 staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of
473.22 the median wage for community social service specialist (SOC code 21-1099); 40 percent
473.23 of the median wage for social and human services aide (SOC code 21-1093); and ten percent
473.24 of the median wage for psychiatric technician (SOC code 29-2053);

473.25 (11) for individualized home supports with training services staff, 40 percent of the
473.26 median wage for community social service specialist (SOC code 21-1099); 50 percent of
473.27 the median wage for social and human services aide (SOC code 21-1093); and ten percent
473.28 of the median wage for psychiatric technician (SOC code 29-2053);

541.12 (12) for independent living skills staff, 40 percent of the median wage for community
541.13 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
541.14 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
541.15 technician (SOC code 29-2053);

541.16 (13) for employment support services staff, 50 percent of the median wage for
541.17 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
541.18 community and social services specialist (SOC code 21-1099);

541.19 (14) for employment exploration services staff, 50 percent of the median wage for
541.20 ~~rehabilitation counselor~~ (SOC code 21-~~1015~~); and 50 percent of the median wage for
541.21 community and social services specialist (SOC code 21-1099);

541.22 (15) for employment development services staff, 50 percent of the median wage for
541.23 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
541.24 of the median wage for community and social services specialist (SOC code 21-1099);

541.25 (16) for individualized home support staff, 50 percent of the median wage for personal
541.26 and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
541.27 assistant (SOC code 31-1014);

541.28 (17) for adult companion staff, 50 percent of the median wage for personal and home
541.29 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
541.30 (SOC code 31-1014);

541.31 (18) for night supervision staff, 20 percent of the median wage for home health aide
541.32 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
541.33 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
542.1 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
542.2 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

542.3 (19) for respite staff, 50 percent of the median wage for personal and home care aide
542.4 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
542.5 31-1014);

542.6 (20) for personal support staff, 50 percent of the median wage for personal and home
542.7 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
542.8 (SOC code 31-1014);

542.9 (21) for supervisory staff, 100 percent of the median wage for community and social
542.10 services specialist (SOC code 21-1099), with the exception of the supervisor of positive
542.11 supports professional, positive supports analyst, and positive supports specialists, which is
542.12 100 percent of the median wage for clinical counseling and school psychologist (SOC code
542.13 19-3031);

542.14 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
542.15 (SOC code 29-1141); and

473.29 (12) for independent living skills staff, 40 percent of the median wage for community
473.30 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
473.31 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
473.32 technician (SOC code 29-2053);

474.1 (13) for employment support services staff, 50 percent of the median wage for
474.2 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
474.3 community and social services specialist (SOC code 21-1099);

474.4 (14) for employment exploration services staff, 50 percent of the median wage for
474.5 ~~rehabilitation counselor~~ (SOC code 21-~~1015~~) education, guidance, school, and vocational
474.6 counselors (SOC code 21-~~1012~~); and 50 percent of the median wage for community and
474.7 social services specialist (SOC code 21-1099);

474.8 (15) for employment development services staff, 50 percent of the median wage for
474.9 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
474.10 of the median wage for community and social services specialist (SOC code 21-1099);

474.11 (16) for individualized home support staff, 50 percent of the median wage for personal
474.12 and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing
474.13 assistant (SOC code 31-1014);

474.14 (17) for adult companion staff, 50 percent of the median wage for personal and home
474.15 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
474.16 (SOC code 31-1014);

474.17 (18) for night supervision staff, 20 percent of the median wage for home health aide
474.18 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
474.19 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
474.20 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
474.21 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

474.22 (19) for respite staff, 50 percent of the median wage for personal and home care aide
474.23 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
474.24 31-1014);

474.25 (20) for personal support staff, 50 percent of the median wage for personal and home
474.26 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant
474.27 (SOC code 31-1014);

474.28 (21) for supervisory staff, 100 percent of the median wage for community and social
474.29 services specialist (SOC code 21-1099), with the exception of the supervisor of positive
474.30 supports professional, positive supports analyst, and positive supports specialists, which is
474.31 100 percent of the median wage for clinical counseling and school psychologist (SOC code
474.32 19-3031);

475.1 (22) for registered nurse staff, 100 percent of the median wage for registered nurses
475.2 (SOC code 29-1141); and

542.16 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
542.17 practical nurses (SOC code 29-2061).

542.18 (b) Component values for corporate foster care services, corporate supportive living
542.19 services daily, community residential services, and integrated community support services
542.20 are:

542.21 (1) competitive workforce factor: 4.7 percent;

542.22 (2) supervisory span of control ratio: 11 percent;

542.23 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

542.24 (4) employee-related cost ratio: 23.6 percent;

542.25 (5) general administrative support ratio: 13.25 percent;

542.26 (6) program-related expense ratio: 1.3 percent; and

542.27 (7) absence and utilization factor ratio: 3.9 percent.

542.28 ~~(c) Component values for family foster care are:~~

542.29 ~~(1) competitive workforce factor: 4.7 percent;~~

542.30 ~~(2) supervisory span of control ratio: 11 percent;~~

543.1 ~~(3) employee vacation, sick, and training allowance ratio: 8.71 percent;~~

543.2 ~~(4) employee-related cost ratio: 23.6 percent;~~

543.3 ~~(5) general administrative support ratio: 3.3 percent;~~

543.4 ~~(6) program-related expense ratio: 1.3 percent; and~~

543.5 ~~(7) absence factor: 1.7 percent.~~

543.6 ~~(d)~~ (c) Component values for day training and habilitation, day support services, and
543.7 prevocational services are:

543.8 (1) competitive workforce factor: 4.7 percent;

543.9 (2) supervisory span of control ratio: 11 percent;

543.10 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

543.11 (4) employee-related cost ratio: 23.6 percent;

543.12 (5) program plan support ratio: 5.6 percent;

543.13 (6) client programming and support ratio: ten percent;

543.14 (7) general administrative support ratio: 13.25 percent;

475.3 (23) for licensed practical nurse staff, 100 percent of the median wage for licensed
475.4 practical nurses (SOC code 29-2061).

475.5 (b) Component values for corporate foster care services, corporate supportive living
475.6 services daily, community residential services, and integrated community support services
475.7 are:

475.8 (1) competitive workforce factor: 4.7 percent;

475.9 (2) supervisory span of control ratio: 11 percent;

475.10 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

475.11 (4) employee-related cost ratio: 23.6 percent;

475.12 (5) general administrative support ratio: 13.25 percent;

475.13 (6) program-related expense ratio: 1.3 percent; and

475.14 (7) absence and utilization factor ratio: 3.9 percent.

475.15 (c) Component values for family foster care are:

475.16 (1) competitive workforce factor: 4.7 percent;

475.17 (2) supervisory span of control ratio: 11 percent;

475.18 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

475.19 (4) employee-related cost ratio: 23.6 percent;

475.20 (5) general administrative support ratio: 3.3 percent;

475.21 (6) program-related expense ratio: 1.3 percent; and

475.22 (7) absence factor: 1.7 percent.

475.23 (d) Component values for day training and habilitation, day support services, and
475.24 prevocational services are:

475.25 (1) competitive workforce factor: 4.7 percent;

475.26 (2) supervisory span of control ratio: 11 percent;

475.27 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

475.28 (4) employee-related cost ratio: 23.6 percent;

476.1 (5) program plan support ratio: 5.6 percent;

476.2 (6) client programming and support ratio: ten percent;

476.3 (7) general administrative support ratio: 13.25 percent;

543.15 (8) program-related expense ratio: 1.8 percent; and
543.16 (9) absence and utilization factor ratio: 9.4 percent.
543.17 (d) Component values for day support services and prevocational services delivered
543.18 remotely are:
543.19 (1) competitive workforce factor: 4.7 percent;
543.20 (2) supervisory span of control ratio: 11 percent;
543.21 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
543.22 (4) employee-related cost ratio: 23.6 percent;
543.23 (5) program plan support ratio: 5.6 percent;
543.24 (6) client programming and support ratio: 7.67 percent;
543.25 (7) general administrative support ratio: 13.25 percent;
543.26 (8) program-related expense ratio: 1.8 percent; and
543.27 (9) absence and utilization factor ratio: 9.4 percent.
543.28 (e) Component values for adult day services are:
544.1 (1) competitive workforce factor: 4.7 percent;
544.2 (2) supervisory span of control ratio: 11 percent;
544.3 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
544.4 (4) employee-related cost ratio: 23.6 percent;
544.5 (5) program plan support ratio: 5.6 percent;
544.6 (6) client programming and support ratio: 7.4 percent;
544.7 (7) general administrative support ratio: 13.25 percent;
544.8 (8) program-related expense ratio: 1.8 percent; and
544.9 (9) absence and utilization factor ratio: 9.4 percent.
544.10 (f) Component values for unit-based services with programming are:
544.11 (1) competitive workforce factor: 4.7 percent;
544.12 (2) supervisory span of control ratio: 11 percent;
544.13 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
544.14 (4) employee-related cost ratio: 23.6 percent;

476.4 (8) program-related expense ratio: 1.8 percent; and
476.5 (9) absence and utilization factor ratio: 9.4 percent.
476.6 (e) Component values for day support services and prevocational services delivered
476.7 remotely are:
476.8 (1) competitive workforce factor: 4.7 percent;
476.9 (2) supervisory span of control ratio: 11 percent;
476.10 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
476.11 (4) employee-related cost ratio: 23.6 percent;
476.12 (5) program plan support ratio: 5.6 percent;
476.13 (6) client programming and support ratio: 10.37 percent;
476.14 (7) general administrative support ratio: 13.25 percent;
476.15 (8) program-related expense ratio: 1.8 percent; and
476.16 (9) absence and utilization factor ratio: 9.4 percent.
476.17 (f) Component values for adult day services are:
476.18 (1) competitive workforce factor: 4.7 percent;
476.19 (2) supervisory span of control ratio: 11 percent;
476.20 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
476.21 (4) employee-related cost ratio: 23.6 percent;
476.22 (5) program plan support ratio: 5.6 percent;
476.23 (6) client programming and support ratio: 7.4 percent;
476.24 (7) general administrative support ratio: 13.25 percent;
476.25 (8) program-related expense ratio: 1.8 percent; and
476.26 (9) absence and utilization factor ratio: 9.4 percent.
476.27 ~~(f)~~ (g) Component values for unit-based services with programming are:
477.1 (1) competitive workforce factor: 4.7 percent;
477.2 (2) supervisory span of control ratio: 11 percent;
477.3 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
477.4 (4) employee-related cost ratio: 23.6 percent;

544.15 (5) program plan supports ratio: 15.5 percent;
544.16 (6) client programming and supports ratio: 4.7 percent;
544.17 (7) general administrative support ratio: 13.25 percent;
544.18 (8) program-related expense ratio: 6.1 percent; and
544.19 (9) absence and utilization factor ratio: 3.9 percent.
544.20 (g) Component values for unit-based services with programming delivered remotely
544.21 are:
544.22 (1) competitive workforce factor: 4.7 percent;
544.23 (2) supervisory span of control ratio: 11 percent;
544.24 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
544.25 (4) employee-related cost ratio: 23.6 percent;
544.26 (5) program plan supports ratio: 5.6 percent;
544.27 (6) client programming and supports ratio: 1.53 percent;
545.1 (7) general administrative support ratio: 13.25 percent;
545.2 (8) program-related expense ratio: 6.1 percent; and
545.3 (9) absence and utilization factor ratio: 3.9 percent.
545.4 ~~(g)~~ (h) Component values for unit-based services without programming except respite
545.5 are:
545.6 (1) competitive workforce factor: 4.7 percent;
545.7 (2) supervisory span of control ratio: 11 percent;
545.8 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
545.9 (4) employee-related cost ratio: 23.6 percent;
545.10 (5) program plan support ratio: 7.0 percent;
545.11 (6) client programming and support ratio: 2.3 percent;
545.12 (7) general administrative support ratio: 13.25 percent;
545.13 (8) program-related expense ratio: 2.9 percent; and
545.14 (9) absence and utilization factor ratio: 3.9 percent.

477.5 (5) program plan supports ratio: 15.5 percent;
477.6 (6) client programming and supports ratio: 4.7 percent;
477.7 (7) general administrative support ratio: 13.25 percent;
477.8 (8) program-related expense ratio: 6.1 percent; and
477.9 (9) absence and utilization factor ratio: 3.9 percent.
477.10 ~~(g)~~ (h) Component values for unit-based services with programming delivered remotely
477.11 are:
477.12 (1) competitive workforce factor: 4.7 percent;
477.13 (2) supervisory span of control ratio: 11 percent;
477.14 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
477.15 (4) employee-related cost ratio: 23.6 percent;
477.16 (5) program plan supports ratio: 15.5 percent;
477.17 (6) client programming and supports ratio: 4.7 percent;
477.18 (7) general administrative support ratio: 13.25 percent;
477.19 (8) program-related expense ratio: 6.1 percent; and
477.20 (9) absence and utilization factor ratio: 3.9 percent.
477.21 (i) Component values for unit-based services without programming except respite are:
477.22 (1) competitive workforce factor: 4.7 percent;
477.23 (2) supervisory span of control ratio: 11 percent;
477.24 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
477.25 (4) employee-related cost ratio: 23.6 percent;
477.26 (5) program plan support ratio: 7.0 percent;
477.27 (6) client programming and support ratio: 2.3 percent;
478.1 (7) general administrative support ratio: 13.25 percent;
478.2 (8) program-related expense ratio: 2.9 percent; and
478.3 (9) absence and utilization factor ratio: 3.9 percent.

545.15 (i) Component values for unit-based services without programming delivered remotely,
545.16 except respite, are:

545.17 (1) competitive workforce factor: 4.7 percent;
545.18 (2) supervisory span of control ratio: 11 percent;
545.19 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
545.20 (4) employee-related cost ratio: 23.6 percent;
545.21 (5) program plan support ratio: 1.3 percent;
545.22 (6) client programming and support ratio: 1.14 percent;
545.23 (7) general administrative support ratio: 13.25 percent;
545.24 (8) program-related expense ratio: 2.9 percent; and
545.25 (9) absence and utilization factor ratio: 3.9 percent.

545.26 ~~(h)~~ (j) Component values for unit-based services without programming for respite are:

545.27 (1) competitive workforce factor: 4.7 percent;
545.28 (2) supervisory span of control ratio: 11 percent;
546.1 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
546.2 (4) employee-related cost ratio: 23.6 percent;
546.3 (5) general administrative support ratio: 13.25 percent;
546.4 (6) program-related expense ratio: 2.9 percent; and
546.5 (7) absence and utilization factor ratio: 3.9 percent.

546.6 ~~(j)~~ (k) On July 1, 2022, and every two years thereafter, the commissioner shall update
546.7 the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor
546.8 Statistics available 30 months and one day prior to the scheduled update. The commissioner
546.9 shall publish these updated values and load them into the rate management system.

546.10 ~~(j)~~ (l) Beginning February 1, 2021, and every two years thereafter, the commissioner
546.11 shall report to the chairs and ranking minority members of the legislative committees and
546.12 divisions with jurisdiction over health and human services policy and finance an analysis
546.13 of the competitive workforce factor. The report must include recommendations to update
546.14 the competitive workforce factor using:

546.15 (1) the most recently available wage data by SOC code for the weighted average wage
546.16 for direct care staff for residential services and direct care staff for day services;

478.4 (j) Component values for unit-based services without programming delivered remotely,
478.5 except respite, are:

478.6 (1) competitive workforce factor: 4.7 percent;
478.7 (2) supervisory span of control ratio: 11 percent;
478.8 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
478.9 (4) employee-related cost ratio: 23.6 percent;
478.10 (5) program plan support ratio: 7.0 percent;
478.11 (6) client programming and support ratio: 2.3 percent;
478.12 (7) general administrative support ratio: 13.25 percent;
478.13 (8) program-related expense ratio: 2.9 percent; and
478.14 (9) absence and utilization factor ratio: 3.9 percent.

478.15 ~~(h)~~ (k) Component values for unit-based services without programming for respite are:

478.16 (1) competitive workforce factor: 4.7 percent;
478.17 (2) supervisory span of control ratio: 11 percent;
478.18 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;
478.19 (4) employee-related cost ratio: 23.6 percent;
478.20 (5) general administrative support ratio: 13.25 percent;
478.21 (6) program-related expense ratio: 2.9 percent; and
478.22 (7) absence and utilization factor ratio: 3.9 percent.

478.23 ~~(j)~~ (l) On July 1, 2022, and every two years thereafter, the commissioner shall update
478.24 the base wage index in paragraph (a) based on wage data by SOC from the Bureau of Labor
478.25 Statistics available 30 months and one day prior to the scheduled update. The commissioner
478.26 shall publish these updated values and load them into the rate management system.

478.27 ~~(j)~~ (m) Beginning February 1, 2021, and every two years thereafter, the commissioner
478.28 shall report to the chairs and ranking minority members of the legislative committees and
478.29 divisions with jurisdiction over health and human services policy and finance an analysis
479.1 of the competitive workforce factor. The report must include recommendations to update
479.2 the competitive workforce factor using:

479.3 (1) the most recently available wage data by SOC code for the weighted average wage
479.4 for direct care staff for residential services and direct care staff for day services;

546.17 (2) the most recently available wage data by SOC code of the weighted average wage
546.18 of comparable occupations; and

546.19 (3) workforce data as required under subdivision 10a, paragraph (g).

546.20 The commissioner shall not recommend an increase or decrease of the competitive workforce
546.21 factor from the current value by more than two percentage points. If, after a biennial analysis
546.22 for the next report, the competitive workforce factor is less than or equal to zero, the
546.23 commissioner shall recommend a competitive workforce factor of zero.

546.24 ~~(k)~~ (m) On July 1, 2022, and every two years thereafter, the commissioner shall update
546.25 the framework components in paragraph ~~(d)~~ (c), clause (6); paragraph ~~(e)~~ (d), clause (6);
546.26 paragraph ~~(f)~~ (e), clause (6); ~~and~~ paragraph ~~(g)~~ (f), clause (6); paragraph (g), clause (6);
546.27 paragraph (h), clause 6; ~~and~~ paragraph (i), clause (6); subdivision 6, paragraphs (b), clauses
546.28 (9) and (10), and (e), clause (10); ~~and~~ subdivision 7, clauses (11), (17), and (18); ~~and~~
546.29 subdivision 18, for changes in the Consumer Price Index. The commissioner shall adjust
546.30 these values higher or lower by the percentage change in the CPI-U from the date of the
546.31 previous update to the data available 30 months and one day prior to the scheduled update.
547.1 The commissioner shall publish these updated values and load them into the rate management
547.2 system.

547.3 ~~(j)~~ (n) Upon the implementation of the updates under paragraphs ~~(i)~~ (k) and ~~(k)~~ (m), rate
547.4 adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108,
547.5 article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed
547.6 from service rates calculated under this section.

547.7 ~~(m)~~ (o) Any rate adjustments applied to the service rates calculated under this section
547.8 outside of the cost components and rate methodology specified in this section shall be
547.9 removed from rate calculations upon implementation of the updates under paragraphs ~~(i)~~
547.10 (k) and ~~(k)~~ (m).

547.11 ~~(n)~~ (p) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
547.12 Price Index items are unavailable in the future, the commissioner shall recommend to the
547.13 legislature codes or items to update and replace missing component values.

547.14 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
547.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
547.16 when federal approval is obtained.

547.17 Sec. 23. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

547.18 Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision,
547.19 residential support services includes 24-hour customized living services, community
547.20 residential services, customized living services, ~~family residential services, foster care~~
547.21 ~~services, and~~ integrated community supports, ~~and supportive living services daily.~~

479.5 (2) the most recently available wage data by SOC code of the weighted average wage
479.6 of comparable occupations; and

479.7 (3) workforce data as required under subdivision 10a, paragraph (g).

479.8 The commissioner shall not recommend an increase or decrease of the competitive workforce
479.9 factor from the current value by more than two percentage points. If, after a biennial analysis
479.10 for the next report, the competitive workforce factor is less than or equal to zero, the
479.11 commissioner shall recommend a competitive workforce factor of zero.

479.12 ~~(k)~~ (n) On July 1, 2022, and every two years thereafter, the commissioner shall update
479.13 the framework components in paragraph (d), clause (6); paragraph (e), clause (6); paragraph
479.14 (f), clause (6); ~~and~~ paragraph (g), clause (6); paragraph (h), clause (6); paragraph (i), clause
479.15 (6); paragraph (j), clause (6); subdivision 6, paragraphs (b), clauses (9) and (10), and (e),
479.16 clause (10); ~~and~~ subdivision 7, clauses (11), (17), and (18), for changes in the Consumer
479.17 Price Index. The commissioner shall adjust these values higher or lower by the percentage
479.18 change in the CPI-U from the date of the previous update to the data available 30 months
479.19 and one day prior to the scheduled update. The commissioner shall publish these updated
479.20 values and load them into the rate management system.

479.21 ~~(j)~~ (o) Upon the implementation of the updates under paragraphs ~~(i)~~ and (k) (l) and (n),
479.22 rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter
479.23 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be
479.24 removed from service rates calculated under this section.

479.25 ~~(m)~~ (p) Any rate adjustments applied to the service rates calculated under this section
479.26 outside of the cost components and rate methodology specified in this section shall be
479.27 removed from rate calculations upon implementation of the updates under paragraphs ~~(i)~~
479.28 ~~and (k)~~ (l) and (n).

479.29 ~~(n)~~ (q) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
479.30 Price Index items are unavailable in the future, the commissioner shall recommend to the
479.31 legislature codes or items to update and replace missing component values.

479.32 **EFFECTIVE DATE.** This section is effective January 1, 2022, six months after the
479.33 end of the federal public health emergency, or upon federal approval, whichever is later.
480.1 The commissioner of human services shall notify the revisor of statutes when the federal
480.2 public health emergency ends and when federal approval is obtained.

480.3 Sec. 37. Minnesota Statutes 2020, section 256B.4914, subdivision 6, is amended to read:

480.4 Subd. 6. **Payments for residential support services.** (a) For purposes of this subdivision,
480.5 residential support services includes 24-hour customized living services, community
480.6 residential services, customized living services, ~~family residential services, foster care~~
480.7 ~~services, integrated community supports, and supportive living services daily.~~

547.22 (b) Payments for community residential services, ~~corporate foster care services, corporate~~
547.23 ~~supportive living services daily, family residential services, and family foster care services~~
547.24 must be calculated as follows:

547.25 (1) determine the number of shared staffing and individual direct staff hours to meet a
547.26 recipient's needs provided on site or through monitoring technology;

547.27 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
547.28 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
547.29 5;

547.30 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
547.31 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
547.32 5, paragraph (b), clause (1);

548.1 (4) for a recipient requiring customization for deaf and hard-of-hearing language
548.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
548.3 to the result of clause (3);

548.4 (5) multiply the number of shared and individual direct staff hours provided on site or
548.5 through monitoring technology and nursing hours by the appropriate staff wages;

548.6 (6) multiply the number of shared and individual direct staff hours provided on site or
548.7 through monitoring technology and nursing hours by the product of the supervision span
548.8 of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision
548.9 wage in subdivision 5, paragraph (a), clause (21);

548.10 (7) combine the results of clauses (5) and (6), excluding any shared and individual direct
548.11 staff hours provided through monitoring technology, and multiply the result by one plus
548.12 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
548.13 clause (3). This is defined as the direct staffing cost;

548.14 (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared
548.15 and individual direct staff hours provided through monitoring technology, by one plus the
548.16 employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

548.17 (9) for client programming and supports, the commissioner shall add \$2,179; and

548.18 (10) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
548.19 customized for adapted transport, based on the resident with the highest assessed need.

548.20 (c) The total rate must be calculated using the following steps:

548.21 (1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared
548.22 and individual direct staff hours provided through monitoring technology that was excluded
548.23 in clause (8);

548.24 (2) sum the standard general and administrative rate, the program-related expense ratio,
548.25 and the absence and utilization ratio;

480.8 (b) Payments for community residential services, ~~corporate foster care services, corporate~~
480.9 ~~supportive living services daily, family residential services, and family foster care services~~
480.10 must be calculated as follows:

480.11 (1) determine the number of shared staffing and individual direct staff hours to meet a
480.12 recipient's needs provided on site or through monitoring technology;

480.13 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
480.14 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
480.15 5;

480.16 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
480.17 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
480.18 5, paragraph (b), clause (1);

480.19 (4) for a recipient requiring customization for deaf and hard-of-hearing language
480.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
480.21 to the result of clause (3);

480.22 (5) multiply the number of shared and individual direct staff hours provided on site or
480.23 through monitoring technology and nursing hours by the appropriate staff wages;

480.24 (6) multiply the number of shared and individual direct staff hours provided on site or
480.25 through monitoring technology and nursing hours by the product of the supervision span
480.26 of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervision
480.27 wage in subdivision 5, paragraph (a), clause (21);

480.28 (7) combine the results of clauses (5) and (6), excluding any shared and individual direct
480.29 staff hours provided through monitoring technology, and multiply the result by one plus
480.30 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
480.31 clause (3). This is defined as the direct staffing cost;

481.1 (8) for employee-related expenses, multiply the direct staffing cost, excluding any shared
481.2 and individual direct staff hours provided through monitoring technology, by one plus the
481.3 employee-related cost ratio in subdivision 5, paragraph (b), clause (4);

481.4 (9) for client programming and supports, the commissioner shall add \$2,179; and

481.5 (10) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
481.6 customized for adapted transport, based on the resident with the highest assessed need.

481.7 (c) The total rate must be calculated using the following steps:

481.8 (1) subtotal paragraph (b), clauses (8) to (10), and the direct staffing cost of any shared
481.9 and individual direct staff hours provided through monitoring technology that was excluded
481.10 in clause (8);

481.11 (2) sum the standard general and administrative rate, the program-related expense ratio,
481.12 and the absence and utilization ratio;

548.26 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
548.27 payment amount; and

548.28 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
548.29 adjust for regional differences in the cost of providing services.

548.30 (d) The payment methodology for customized living, 24-hour customized living, and
548.31 residential care services must be the customized living tool. Revisions to the customized
548.32 living tool must be made to reflect the services and activities unique to disability-related
549.1 recipient needs. Customized living and 24-hour customized living rates determined under
549.2 this section shall not include more than 24 hours of support in a daily unit. The commissioner
549.3 shall establish acuity-based input limits, based on case mix, for customized living and
549.4 24-hour customized living rates determined under this section.

549.5 (e) Payments for integrated community support services must be calculated as follows:

549.6 (1) the base shared staffing shall be eight hours divided by the number of people receiving
549.7 support in the integrated community support setting;

549.8 (2) the individual staffing hours shall be the average number of direct support hours
549.9 provided directly to the service recipient;

549.10 (3) the personnel hourly wage rate must be based on the most recent Bureau of Labor
549.11 Statistics Minnesota-specific rates or rates derived by the commissioner as provided in
549.12 subdivision 5;

549.13 (4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
549.14 result of clause (3) by the product of one plus the competitive workforce factor in subdivision
549.15 5, paragraph (b), clause (1);

549.16 (5) for a recipient requiring customization for deaf and hard-of-hearing language
549.17 accessibility under subdivision 12, add the customization rate provided in subdivision 12
549.18 to the result of clause (4);

549.19 (6) multiply the number of shared and individual direct staff hours in clauses (1) and
549.20 (2) by the appropriate staff wages;

549.21 (7) multiply the number of shared and individual direct staff hours in clauses (1) and
549.22 (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b),
549.23 clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause
549.24 (21);

549.25 (8) combine the results of clauses (6) and (7) and multiply the result by one plus the
549.26 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause
549.27 (3). This is defined as the direct staffing cost;

481.13 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
481.14 payment amount; and

481.15 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
481.16 adjust for regional differences in the cost of providing services.

481.17 (d) The payment methodology for customized living and, 24-hour customized living,
481.18 and residential care services must be the customized living tool. Revisions to The
481.19 commissioner shall revise the customized living tool must be made to reflect the services
481.20 and activities unique to disability-related recipient needs, adjust for regional differences in
481.21 the cost of providing services, and the rate adjustments described in section 256S.205.
481.22 Customized living and 24-hour customized living rates determined under this section shall
481.23 not include more than 24 hours of support in a daily unit. The commissioner shall establish
481.24 acuity-based input limits, based on case mix, for customized living and 24-hour customized
481.25 living rates determined under this section.

481.26 (e) Payments for integrated community support services must be calculated as follows:

481.27 (1) the base shared staffing shall must be eight hours divided by the number of people
481.28 receiving support in the integrated community support setting;

481.29 (2) the individual staffing hours shall must be the average number of direct support hours
481.30 provided directly to the service recipient;

482.1 (3) the personnel hourly wage rate must be based on the most recent Bureau of Labor
482.2 Statistics Minnesota-specific rates or rates derived by the commissioner as provided in
482.3 subdivision 5;

482.4 (4) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
482.5 result of clause (3) by the product of one plus the competitive workforce factor in subdivision
482.6 5, paragraph (b), clause (1);

482.7 (5) for a recipient requiring customization for deaf and hard-of-hearing language
482.8 accessibility under subdivision 12, add the customization rate provided in subdivision 12
482.9 to the result of clause (4);

482.10 (6) multiply the number of shared and individual direct staff hours in clauses (1) and
482.11 (2) by the appropriate staff wages;

482.12 (7) multiply the number of shared and individual direct staff hours in clauses (1) and
482.13 (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b),
482.14 clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause
482.15 (21);

482.16 (8) combine the results of clauses (6) and (7) and multiply the result by one plus the
482.17 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause
482.18 (3). This is defined as the direct staffing cost;

549.28 (9) for employee-related expenses, multiply the direct staffing cost by one plus the
549.29 employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

549.30 (10) for client programming and supports, the commissioner shall add \$2,260.21 divided
549.31 by 365.

549.32 (f) The total rate must be calculated as follows:

550.1 (1) add the results of paragraph (e), clauses (9) and (10);

550.2 (2) add the standard general and administrative rate, the program-related expense ratio,
550.3 and the absence and utilization factor ratio;

550.4 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
550.5 payment amount; and

550.6 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
550.7 adjust for regional differences in the cost of providing services.

550.8 (g) The payment methodology for customized living and 24-hour customized living
550.9 services must be the customized living tool. The commissioner shall revise the customized
550.10 living tool to reflect the services and activities unique to disability-related recipient needs
550.11 and adjust for regional differences in the cost of providing services.

550.12 (h) The number of days authorized for all individuals enrolling in residential services
550.13 must include every day that services start and end.

550.14 EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval,
550.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
550.16 when federal approval is obtained.

550.17 Sec. 24. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

550.18 Subd. 7. **Payments for day programs.** Payments for services with day programs
550.19 including adult day services, day treatment and habilitation, day support services,
550.20 prevocational services, and structured day services, provided in person or remotely, must
550.21 be calculated as follows:

550.22 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

550.23 (i) the staffing ratios for the units of service provided to a recipient in a typical week
550.24 must be averaged to determine an individual's staffing ratio; and

550.25 (ii) the commissioner, in consultation with service providers, shall develop a uniform
550.26 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

550.27 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
550.28 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
550.29 5;

482.19 (9) for employee-related expenses, multiply the direct staffing cost by one plus the
482.20 employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

482.21 (10) for client programming and supports, the commissioner shall add \$2,260.21 divided
482.22 by 365.

482.23 (f) The total rate must be calculated as follows:

482.24 (1) add the results of paragraph (e), clauses (9) and (10);

482.25 (2) add the standard general and administrative rate, the program-related expense ratio,
482.26 and the absence and utilization factor ratio;

482.27 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
482.28 payment amount; and

482.29 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
482.30 adjust for regional differences in the cost of providing services.

482.31 ~~(g) The payment methodology for customized living and 24-hour customized living~~
482.32 ~~services must be the customized living tool. The commissioner shall revise the customized~~
483.1 ~~living tool to reflect the services and activities unique to disability-related recipient needs~~
483.2 ~~and adjust for regional differences in the cost of providing services.~~

483.3 ~~(h)~~(g) The number of days authorized for all individuals enrolling in residential services
483.4 must include every day that services start and end.

483.5 EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval,
483.6 whichever is later, except the fourth sentence of paragraph (d) is effective January 1, 2022.
483.7 The commissioner of human services shall notify the revisor of statutes when federal approval
483.8 is obtained.

483.9 Sec. 38. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

483.10 Subd. 7. **Payments for day programs.** Payments for services with day programs
483.11 including adult day services, day treatment and habilitation, day support services,
483.12 prevocational services, and structured day services provided in person or remotely must be
483.13 calculated as follows:

483.14 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

483.15 (i) the staffing ratios for the units of service provided to a recipient in a typical week
483.16 must be averaged to determine an individual's staffing ratio; and

483.17 (ii) the commissioner, in consultation with service providers, shall develop a uniform
483.18 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

483.19 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
483.20 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
483.21 5;

551.1 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
551.2 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
551.3 5, paragraph ~~(d)~~ (c), clause (1);

551.4 (4) for a recipient requiring customization for deaf and hard-of-hearing language
551.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
551.6 to the result of clause (3);

551.7 (5) multiply the number of day program direct staff hours and nursing hours by the
551.8 appropriate staff wage;

551.9 (6) multiply the number of day direct staff hours by the product of the supervision span
551.10 of control ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (2), for in-person services or
551.11 subdivision 5, paragraph (d), clause (2), for remote services, and the appropriate supervision
551.12 wage in subdivision 5, paragraph (a), clause (21);

551.13 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
551.14 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (c),
551.15 clause (3), for in-person services or subdivision 5, paragraph (d), clause (3), for remote
551.16 services. This is defined as the direct staffing rate;

551.17 (8) for program plan support, multiply the result of clause (7) by one plus the program
551.18 plan support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (5), for in-person services or
551.19 subdivision 5, paragraph (d), clause (5), for remote services;

551.20 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
551.21 employee-related cost ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (4), for in-person
551.22 services or subdivision 5, paragraph (d), clause (4), for remote services;

551.23 (10) for client programming and supports, multiply the result of clause (9) by one plus
551.24 the client programming and support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (6), for
551.25 in-person services or subdivision 5, paragraph (d), clause (6), for remote services;

551.26 (11) for program facility costs, add \$19.30 per week with consideration of staffing ratios
551.27 to meet individual needs for in-person service only;

551.28 (12) for adult day bath services, add \$7.01 per 15 minute unit;

551.29 (13) this is the subtotal rate;

551.30 (14) sum the standard general and administrative rate, the program-related expense ratio,
551.31 and the absence and utilization factor ratio;

552.1 (15) divide the result of clause (13) by one minus the result of clause (14). This is the
552.2 total payment amount;

552.3 (16) adjust the result of clause (15) by a factor to be determined by the commissioner
552.4 to adjust for regional differences in the cost of providing services;

483.22 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
483.23 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
483.24 5, paragraph (d), clause (1);

483.25 (4) for a recipient requiring customization for deaf and hard-of-hearing language
483.26 accessibility under subdivision 12, add the customization rate provided in subdivision 12
483.27 to the result of clause (3);

483.28 (5) multiply the number of day program direct staff hours and nursing hours by the
483.29 appropriate staff wage;

483.30 (6) multiply the number of day direct staff hours by the product of the supervision span
483.31 of control ratio in subdivision 5, paragraph (d), clause (2), for in-person services or
484.1 subdivision 5, paragraph (e), clause (2), for remote services, and the appropriate supervision
484.2 wage in subdivision 5, paragraph (a), clause (21);

484.3 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
484.4 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause
484.5 (3), for in-person services or subdivision 5, paragraph (e), clause (3), for remote services.
484.6 This is defined as the direct staffing rate;

484.7 (8) for program plan support, multiply the result of clause (7) by one plus the program
484.8 plan support ratio in subdivision 5, paragraph (d), clause (5), for in-person services or
484.9 subdivision 5, paragraph (e), clause (5), for remote services;

484.10 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
484.11 employee-related cost ratio in subdivision 5, paragraph (d), clause (4), for in-person services
484.12 or subdivision 5, paragraph (e), clause (4), for remote services;

484.13 (10) for client programming and supports, multiply the result of clause (9) by one plus
484.14 the client programming and support ratio in subdivision 5, paragraph (d), clause (6), for
484.15 in-person services or subdivision 5, paragraph (e), clause (6), for remote services;

484.16 (11) for program facility costs, add ~~\$19.30~~ \$20.02 per week with consideration of staffing
484.17 ratios to meet individual needs;

484.18 (12) for adult day bath services, add \$7.01 per 15 minute unit;

484.19 (13) this is the subtotal rate;

484.20 (14) sum the standard general and administrative rate, the program-related expense ratio,
484.21 and the absence and utilization factor ratio;

484.22 (15) divide the result of clause (13) by one minus the result of clause (14). This is the
484.23 total payment amount;

484.24 (16) adjust the result of clause (15) by a factor to be determined by the commissioner
484.25 to adjust for regional differences in the cost of providing services;

552.5 (17) for transportation provided as part of day training and habilitation for an individual
552.6 who does not require a lift, add:

552.7 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
552.8 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
552.9 vehicle with a lift;

552.10 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
552.11 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
552.12 vehicle with a lift;

552.13 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
552.14 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
552.15 vehicle with a lift; or

552.16 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
552.17 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
552.18 with a lift;

552.19 (18) for transportation provided as part of day training and habilitation for an individual
552.20 who does require a lift, add:

552.21 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
552.22 lift, and \$15.05 for a shared ride in a vehicle with a lift;

552.23 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
552.24 lift, and \$28.16 for a shared ride in a vehicle with a lift;

552.25 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
552.26 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

552.27 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
552.28 and \$80.93 for a shared ride in a vehicle with a lift.

552.29 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
552.30 whichever is later. The commissioner of human services shall notify the revisor of statutes
552.31 when federal approval is obtained.

553.1 Sec. 25. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

553.2 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
553.3 services with programming, including employment exploration services, employment
553.4 development services, housing access coordination, individualized home supports with
553.5 family training, individualized home supports with training, in-home family support,
553.6 independent living skills training, and hourly supported living services provided to an
553.7 individual outside of any day or residential service plan, provided in person or remotely.

484.26 (17) for transportation provided as part of day training and habilitation for an individual
484.27 who does not require a lift, add:

484.28 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
484.29 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
484.30 vehicle with a lift;

485.1 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
485.2 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
485.3 vehicle with a lift;

485.4 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
485.5 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
485.6 vehicle with a lift; or

485.7 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
485.8 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
485.9 with a lift;

485.10 (18) for transportation provided as part of day training and habilitation for an individual
485.11 who does require a lift, add:

485.12 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
485.13 lift, and \$15.05 for a shared ride in a vehicle with a lift;

485.14 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
485.15 lift, and \$28.16 for a shared ride in a vehicle with a lift;

485.16 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
485.17 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

485.18 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
485.19 and \$80.93 for a shared ride in a vehicle with a lift.

485.20 **EFFECTIVE DATE.** This section is effective January 1, 2022, six months after the
485.21 end of the federal public health emergency, or upon federal approval, whichever is later.
485.22 The commissioner of human services shall notify the revisor of statutes when the federal
485.23 public health emergency ends and when federal approval is obtained.

485.24 Sec. 39. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

485.25 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
485.26 services with programming, including employment exploration services, employment
485.27 development services, housing access coordination, individualized home supports with
485.28 family training, individualized home supports with training, in-home family support,
485.29 independent living skills training, and hourly supported living services provided to an
485.30 individual outside of any day or residential service plan provided in person or remotely

553.8 must be calculated as follows, unless the services are authorized separately under subdivision
553.9 6 or 7:

553.10 (1) determine the number of units of service to meet a recipient's needs;

553.11 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
553.12 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
553.13 5;

553.14 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
553.15 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
553.16 5, paragraph (f), clause (1);

553.17 (4) for a recipient requiring customization for deaf and hard-of-hearing language
553.18 accessibility under subdivision 12, add the customization rate provided in subdivision 12
553.19 to the result of clause (3);

553.20 (5) multiply the number of direct staff hours by the appropriate staff wage;

553.21 (6) multiply the number of direct staff hours by the product of the supervision span of
553.22 control ratio in subdivision 5, paragraph (f), clause (2), for in-person services or subdivision
553.23 5, paragraph (g), clause (2), for remote services, and the appropriate supervision wage in
553.24 subdivision 5, paragraph (a), clause (21);

553.25 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
553.26 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
553.27 (3), for in-person services or subdivision 5, paragraph (g), clause (3), for remote services.
553.28 This is defined as the direct staffing rate;

553.29 (8) for program plan support, multiply the result of clause (7) by one plus the program
553.30 plan supports ratio in subdivision 5, paragraph (f), clause (5), for in-person services or
553.31 subdivision 5, paragraph (g), clause (5), for remote services;

554.1 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
554.2 employee-related cost ratio in subdivision 5, paragraph (f), clause (4), for in-person services
554.3 or subdivision 5, paragraph (g), clause (4), for remote services;

554.4 (10) for client programming and supports, multiply the result of clause (9) by one plus
554.5 the client programming and supports ratio in subdivision 5, paragraph (f), clause (6), for
554.6 in-person services or subdivision 5, paragraph (g), clause (6), for remote services;

554.7 (11) this is the subtotal rate;

554.8 (12) sum the standard general and administrative rate, the program-related expense ratio,
554.9 and the absence and utilization factor ratio;

554.10 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
554.11 total payment amount;

485.31 must be calculated as follows, unless the services are authorized separately under subdivision
485.32 6 or 7:

486.1 (1) determine the number of units of service to meet a recipient's needs;

486.2 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
486.3 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
486.4 5;

486.5 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
486.6 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
486.7 5, paragraph ~~(f)~~ (g), clause (1);

486.8 (4) for a recipient requiring customization for deaf and hard-of-hearing language
486.9 accessibility under subdivision 12, add the customization rate provided in subdivision 12
486.10 to the result of clause (3);

486.11 (5) multiply the number of direct staff hours by the appropriate staff wage;

486.12 (6) multiply the number of direct staff hours by the product of the supervision span of
486.13 control ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (2), for in-person services or
486.14 subdivision 5, paragraph (h), clause (2), for remote services, and the appropriate supervision
486.15 wage in subdivision 5, paragraph (a), clause (21);

486.16 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
486.17 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (g),
486.18 clause (3), for in-person services or subdivision 5, paragraph (h), clause (3), for remote
486.19 services. This is defined as the direct staffing rate;

486.20 (8) for program plan support, multiply the result of clause (7) by one plus the program
486.21 plan supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (5), for in-person services or
486.22 subdivision 5, paragraph (h), clause (5), for remote services;

486.23 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
486.24 employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (4), for in-person
486.25 services or subdivision 5, paragraph (h), clause (4), for remote services;

486.26 (10) for client programming and supports, multiply the result of clause (9) by one plus
486.27 the client programming and supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (6),
486.28 for in-person services or subdivision 5, paragraph (h), clause (6), for remote services;

486.29 (11) this is the subtotal rate;

486.30 (12) sum the standard general and administrative rate, the program-related expense ratio,
486.31 and the absence and utilization factor ratio;

487.1 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
487.2 total payment amount;

554.12 (14) for employment exploration services provided in a shared manner, divide the total
554.13 payment amount in clause (13) by the number of service recipients, not to exceed five. For
554.14 employment support services provided in a shared manner, divide the total payment amount
554.15 in clause (13) by the number of service recipients, not to exceed six. For independent living
554.16 skills training, individualized home supports with training, and individualized home supports
554.17 with family training provided in a shared manner, divide the total payment amount in clause
554.18 (13) by the number of service recipients, not to exceed two; and

554.19 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
554.20 to adjust for regional differences in the cost of providing services.

554.21 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
554.22 whichever is later. The commissioner of human services shall notify the revisor of statutes
554.23 when federal approval is obtained.

554.24 Sec. 26. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

554.25 Subd. 9. **Payments for unit-based services without programming.** Payments for
554.26 unit-based services without programming, including individualized home supports, night
554.27 supervision, personal support, respite, and companion care provided to an individual outside
554.28 of any day or residential service plan, provided in person or remotely, must be calculated
554.29 as follows unless the services are authorized separately under subdivision 6 or 7:

554.30 (1) for all services except respite, determine the number of units of service to meet a
554.31 recipient's needs;

555.1 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
555.2 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

555.3 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
555.4 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
555.5 5, paragraph ~~(g)~~ (h), clause (1);

555.6 (4) for a recipient requiring customization for deaf and hard-of-hearing language
555.7 accessibility under subdivision 12, add the customization rate provided in subdivision 12
555.8 to the result of clause (3);

555.9 (5) multiply the number of direct staff hours by the appropriate staff wage;

487.3 (14) for employment exploration services provided in a shared manner, divide the total
487.4 payment amount in clause (13) by the number of service recipients, not to exceed five. For
487.5 employment support services provided in a shared manner, divide the total payment amount
487.6 in clause (13) by the number of service recipients, not to exceed six. For independent living
487.7 skills training, individualized home supports with training, and individualized home supports
487.8 with family training provided in a shared manner, divide the total payment amount in clause
487.9 (13) by the number of service recipients, not to exceed two. For individualized home supports
487.10 with training, provided in a shared manner, including for a day unit of individualized home
487.11 supports with training provided in a shared manner, divide the total payment amount in
487.12 clause (13) by the number of service recipients, not to exceed three; and

487.13 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
487.14 to adjust for regional differences in the cost of providing services.

487.15 **EFFECTIVE DATE.** (a) Except for the amendment to clause (14), this section is
487.16 effective January 1, 2022, six months after the end of the federal public health emergency,
487.17 or upon federal approval, whichever is later. The commissioner of human services shall
487.18 notify the revisor of statutes when the federal public health emergency ends and when
487.19 federal approval is obtained.

487.20 (b) The amendment to clause (14) is effective January 1, 2022, or upon federal approval,
487.21 whichever is later. The commissioner of human services shall notify the revisor of statutes
487.22 when federal approval is obtained.

487.23 Sec. 40. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

487.24 Subd. 9. **Payments for unit-based services without programming.** Payments for
487.25 unit-based services without programming, including individualized home supports, night
487.26 supervision, personal support, respite, and companion care provided to an individual outside
487.27 of any day or residential service plan provided in person or remotely must be calculated as
487.28 follows unless the services are authorized separately under subdivision 6 or 7:

487.29 (1) for all services except respite, determine the number of units of service to meet a
487.30 recipient's needs;

487.31 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
487.32 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

488.1 (3) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
488.2 result of clause (2) by the product of one plus the competitive workforce factor in subdivision
488.3 5, paragraph ~~(g)~~ (i), clause (1);

488.4 (4) for a recipient requiring customization for deaf and hard-of-hearing language
488.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
488.6 to the result of clause (3);

488.7 (5) multiply the number of direct staff hours by the appropriate staff wage;

555.10 (6) multiply the number of direct staff hours by the product of the supervision span of
555.11 control ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (2), for in-person services or
555.12 subdivision 5, paragraph (i), clause (2), for remote services, and the appropriate supervision
555.13 wage in subdivision 5, paragraph (a), clause (21);

555.14 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
555.15 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (h),
555.16 clause (3), for in-person services or subdivision 5, paragraph (i), clause (3), for remote
555.17 services. This is defined as the direct staffing rate;

555.18 (8) for program plan support, multiply the result of clause (7) by one plus the program
555.19 plan support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (5), for in-person services or
555.20 subdivision 5, paragraph (i), clause (5), for remote services;

555.21 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
555.22 employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (4), for in-person
555.23 services or subdivision 5, paragraph (i), clause (4), for remote services;

555.24 (10) for client programming and supports, multiply the result of clause (9) by one plus
555.25 the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (6), for
555.26 in-person services or subdivision 5, paragraph (i), clause (6), for remote services;

555.27 (11) this is the subtotal rate;

555.28 (12) sum the standard general and administrative rate, the program-related expense ratio,
555.29 and the absence and utilization factor ratio;

555.30 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
555.31 total payment amount;

556.1 (14) for respite services, determine the number of day units of service to meet an
556.2 individual's needs;

556.3 (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
556.4 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

556.5 (16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
556.6 result of clause (15) by the product of one plus the competitive workforce factor in
556.7 subdivision 5, paragraph ~~(h)~~ (j), clause (1);

556.8 (17) for a recipient requiring deaf and hard-of-hearing customization under subdivision
556.9 12, add the customization rate provided in subdivision 12 to the result of clause (16);

556.10 (18) multiply the number of direct staff hours by the appropriate staff wage;

556.11 (19) multiply the number of direct staff hours by the product of the supervisory span of
556.12 control ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (2), and the appropriate supervision
556.13 wage in subdivision 5, paragraph (a), clause (21);

488.8 (6) multiply the number of direct staff hours by the product of the supervision span of
488.9 control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (2), for in-person services or
488.10 subdivision 5, paragraph (j), clause (2), for remote services, and the appropriate supervision
488.11 wage in subdivision 5, paragraph (a), clause (21);

488.12 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
488.13 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (i),
488.14 clause (3), for in-person services or subdivision 5, paragraph (j), clause (3), for remote
488.15 services. This is defined as the direct staffing rate;

488.16 (8) for program plan support, multiply the result of clause (7) by one plus the program
488.17 plan support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (5), for in-person services or
488.18 subdivision 5, paragraph (j), clause (5), for remote services;

488.19 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
488.20 employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (4), for in-person
488.21 services or subdivision 5, paragraph (j), clause (4), for remote services;

488.22 (10) for client programming and supports, multiply the result of clause (9) by one plus
488.23 the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (6), for
488.24 in-person services or subdivision 5, paragraph (j), clause (6), for remote services;

488.25 (11) this is the subtotal rate;

488.26 (12) sum the standard general and administrative rate, the program-related expense ratio,
488.27 and the absence and utilization factor ratio;

488.28 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
488.29 total payment amount;

488.30 (14) for respite services, determine the number of day units of service to meet an
488.31 individual's needs;

489.1 (15) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
489.2 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

489.3 (16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the
489.4 result of clause (15) by the product of one plus the competitive workforce factor in
489.5 subdivision 5, paragraph ~~(h)~~ (k), clause (1);

489.6 (17) for a recipient requiring deaf and hard-of-hearing customization under subdivision
489.7 12, add the customization rate provided in subdivision 12 to the result of clause (16);

489.8 (18) multiply the number of direct staff hours by the appropriate staff wage;

489.9 (19) multiply the number of direct staff hours by the product of the supervisory span of
489.10 control ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (2), and the appropriate supervision
489.11 wage in subdivision 5, paragraph (a), clause (21);

556.14 (20) combine the results of clauses (18) and (19), and multiply the result by one plus
556.15 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~
556.16 (j), clause (3). This is defined as the direct staffing rate;

556.17 (21) for employee-related expenses, multiply the result of clause (20) by one plus the
556.18 employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (4);

556.19 (22) this is the subtotal rate;

556.20 (23) sum the standard general and administrative rate, the program-related expense ratio,
556.21 and the absence and utilization factor ratio;

556.22 (24) divide the result of clause (22) by one minus the result of clause (23). This is the
556.23 total payment amount;

556.24 (25) for individualized home supports provided in a shared manner, divide the total
556.25 payment amount in clause (13) by the number of service recipients, not to exceed two;

556.26 (26) for respite care services provided in a shared manner, divide the total payment
556.27 amount in clause (24) by the number of service recipients, not to exceed three; and

556.28 (27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the
556.29 commissioner to adjust for regional differences in the cost of providing services.

557.1 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
557.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
557.3 when federal approval is obtained.

557.4 Sec. 27. Minnesota Statutes 2020, section 256B.4914, is amended by adding a subdivision
557.5 to read:

557.6 Subd. 18. Payments for family residential services. The commissioner shall establish
557.7 rates for family residential services based on a person's assessed needs as described in the
557.8 federally approved waiver plans.

557.9 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
557.10 whichever is later. The commissioner of human services shall notify the revisor of statutes
557.11 when federal approval is obtained.

489.12 (20) combine the results of clauses (18) and (19), and multiply the result by one plus
489.13 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~
489.14 (k), clause (3). This is defined as the direct staffing rate;

489.15 (21) for employee-related expenses, multiply the result of clause (20) by one plus the
489.16 employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (4);

489.17 (22) this is the subtotal rate;

489.18 (23) sum the standard general and administrative rate, the program-related expense ratio,
489.19 and the absence and utilization factor ratio;

489.20 (24) divide the result of clause (22) by one minus the result of clause (23). This is the
489.21 total payment amount;

489.22 (25) for individualized home supports provided in a shared manner, divide the total
489.23 payment amount in clause (13) by the number of service recipients, not to exceed two;

489.24 (26) for respite care services provided in a shared manner, divide the total payment
489.25 amount in clause (24) by the number of service recipients, not to exceed three; and

489.26 (27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the
489.27 commissioner to adjust for regional differences in the cost of providing services.

489.28 **EFFECTIVE DATE.** This section is effective January 1, 2022, six months after the
489.29 end of the federal public health emergency, or upon federal approval, whichever is later.
489.30 The commissioner of human services shall notify the revisor of statutes when the federal
489.31 public health emergency ends and when federal approval is obtained.

490.1 Sec. 41. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision
490.2 to read:

490.3 Subd. 18. ICF/DD rate increases effective July 1, 2021. (a) For the rate period beginning
490.4 July 1, 2021, the commissioner must increase operating payments for each facility reimbursed

490.5 under this section equal to five percent of the operating payment rates in effect on June 30,
490.6 2021.

490.7 (b) For each facility, the commissioner must apply the rate increase based on occupied
490.8 beds, using the percentage specified in this subdivision multiplied by the total payment rate,
490.9 including the variable rate but excluding the property-related payment rate in effect on June
490.10 30, 2021. The total rate increase must include the adjustment provided in section 256B.501,
490.11 subdivision 12.

490.12 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
490.13 whichever is later. The commissioner of human services shall inform the revisor of statutes
490.14 when federal approval is obtained.

490.15 Sec. 42. Minnesota Statutes 2020, section 256B.5013, subdivision 1, is amended to read:

490.16 Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after
490.17 October 1, 2000, When there is a documented increase in the needs of a current ICF/DD
490.18 recipient, the county of financial responsibility may recommend a variable rate to enable
490.19 the facility to meet the individual's increased needs. Variable rate adjustments made under
490.20 this subdivision replace payments for persons with special needs for crisis intervention
490.21 services under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a
490.22 base rate above the 50th percentile of the statewide average reimbursement rate for a Class
490.23 A facility or Class B facility, whichever matches the facility licensure, are not eligible for
490.24 a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,
490.25 except when approved for purposes established in paragraph (b), clause (1). Once approved,
490.26 variable rate adjustments must continue to remain in place unless there is an identified
490.27 change in need. A review of needed resources must be done at the time of the individual's
490.28 annual support plan meeting. Any change in need identified must result in submission of a
490.29 request to adjust the resources for the individual. Variable rate adjustments approved solely
490.30 on the basis of changes on a developmental disabilities screening document will end June
490.31 30, 2002.

490.32 (b) The county of financial responsibility must act on a variable rate request within 30
490.33 days and notify the initiator of the request of the county's recommendation in writing.

491.1 ~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility
491.2 for increased needs in the following situations:

491.3 (1) a need for resources due to an individual's full or partial retirement from participation
491.4 in a day training and habilitation service when the individual: (i) has reached the age of 65
491.5 or has a change in health condition that makes it difficult for the person to participate in
491.6 day training and habilitation services over an extended period of time because it is medically
491.7 contraindicated; and (ii) has expressed a desire for change through the developmental
491.8 disability screening process under section 256B.092;

491.9 (2) a need for additional resources for intensive short-term programming which that is
491.10 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

- 491.11 (3) a demonstrated medical need that significantly impacts the type or amount of services
491.12 needed by the individual; ~~or~~
- 491.13 (4) a demonstrated behavioral or cognitive need that significantly impacts the type or
491.14 amount of services needed by the individual; ~~or~~
- 491.15 ~~(e) The county of financial responsibility must justify the purpose, the projected length~~
491.16 ~~of time, and the additional funding needed for the facility to meet the needs of the individual.~~
- 491.17 (d) The facility shall provide an annual report to the county case manager on the use of
491.18 the variable rate funds and the status of the individual on whose behalf the funds were
491.19 approved. The county case manager will forward the facility's report with a recommendation
491.20 to the commissioner to approve or disapprove a continuation of the variable rate.
- 491.21 (e) Funds made available through the variable rate process that are not used by the facility
491.22 to meet the needs of the individual for whom they were approved shall be returned to the
491.23 state.
- 491.24 (5) a demonstrated increased need for staff assistance, changes in the type of staff
491.25 credentials needed, or a need for expert consultation based on assessments conducted prior
491.26 to the annual support plan meeting.
- 491.27 (d) Variable rate requests must include the following information:
- 491.28 (1) the service needs change;
- 491.29 (2) the variable rate requested and the difference from the current rate;
- 491.30 (3) a basis for the underlying costs used for the variable rate and any accompanying
491.31 documentation; and
- 492.1 (4) documentation of the expected outcomes to be achieved and the frequency of progress
492.2 monitoring associated with the rate increase.
- 492.3 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
492.4 whichever is later. The commissioner of human services shall inform the revisor of statutes
492.5 when federal approval is obtained.
- 492.6 Sec. 43. Minnesota Statutes 2020, section 256B.5013, subdivision 6, is amended to read:
- 492.7 Subd. 6. **Commissioner's responsibilities.** The commissioner shall:
- 492.8 (1) make a determination to approve, deny, or modify a request for a variable rate
492.9 adjustment within 30 days of the receipt of the completed application;
- 492.10 (2) notify the ICF/DD facility and county case manager of the ~~duration and conditions~~
492.11 ~~of variable rate adjustment approvals~~ determination; and
- 492.12 (3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved
492.13 variable rates.

557.12 Sec. 28. Minnesota Statutes 2020, section 256B.69, subdivision 5a, is amended to read:

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

492.14 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
492.15 whichever is later. The commissioner of human services shall inform the revisor of statutes
492.16 when federal approval is obtained.

492.17 Sec. 44. Minnesota Statutes 2020, section 256B.5015, subdivision 2, is amended to read:

492.18 Subd. 2. **Services during the day.** (a) Services during the day, as defined in section
492.19 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through
492.20 payment no later than January 1, 2004. The commissioner shall establish rates for these
492.21 services, other than day training and habilitation services, at levels that do not exceed 75
492.22 100 percent of a recipient's day training and habilitation service costs prior to the service
492.23 change.

492.24 (b) An individual qualifies for services during the day under paragraph (a) if, through
492.25 consultation with the individual and the individual's support team or interdisciplinary team:

492.26 (1) it has been determined that the individual's needs can best be met through partial or
492.27 full retirement from:

492.28 (i) participation in a day training and habilitation service; or

492.29 (ii) the use of services during the day in the individual's home environment; and

492.30 (2) an individualized plan has been developed with designated outcomes that:

493.1 (i) address the support needs and desires contained in the person-centered plan or
493.2 individual support plan; and

493.3 (ii) include goals that focus on community integration as appropriate for the individual.

493.4 (c) When establishing a rate for these services, the commissioner shall also consider an
493.5 individual recipient's needs as identified in the individualized service individual support
493.6 plan and the person's need for active treatment as defined under federal regulations. The
493.7 pass-through payments for services during the day shall be paid separately by the
493.8 commissioner and shall not be included in the computation of the ICF/DD facility total
493.9 payment rate.

493.10 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
493.11 whichever is later. The commissioner of human services shall inform the revisor of statutes
493.12 when federal approval is obtained.

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

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

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

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

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

558.21 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
558.22 include as part of the performance targets described in paragraph (c) a reduction in the health
558.23 plan's emergency department utilization rate for medical assistance and MinnesotaCare
558.24 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on

558.25 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
558.26 year, the managed care plan or county-based purchasing plan must achieve a qualifying
558.27 reduction of no less than ten percent of the plan's emergency department utilization rate for
558.28 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
558.29 in subdivisions 23 and 28, compared to the previous measurement year until the final
558.30 performance target is reached. When measuring performance, the commissioner must
558.31 consider the difference in health risk in a managed care or county-based purchasing plan's
558.32 membership in the baseline year compared to the measurement year, and work with the
558.33 managed care or county-based purchasing plan to account for differences that they agree
558.34 are significant.

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

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

559.13 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
559.14 include as part of the performance targets described in paragraph (c) a reduction in the plan's
559.15 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
559.16 determined by the commissioner. To earn the return of the withhold each year, the managed
559.17 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
559.18 than five percent of the plan's hospital admission rate for medical assistance and
559.19 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
559.20 28, compared to the previous calendar year until the final performance target is reached.
559.21 When measuring performance, the commissioner must consider the difference in health risk
559.22 in a managed care or county-based purchasing plan's membership in the baseline year
559.23 compared to the measurement year, and work with the managed care or county-based
559.24 purchasing plan to account for differences that they agree are significant.

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

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

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

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

560.18 The withhold described in this paragraph must continue for each consecutive contract
560.19 period until the plan's subsequent hospitalization rate for medical assistance and
560.20 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
560.21 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
560.22 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
560.23 accept payment withholds that must be returned to the hospitals if the performance target
560.24 is achieved.

560.25 (h) Effective for services rendered on or after January 1, 2013, through December 31,
560.26 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
560.27 this section and county-based purchasing plan payments under section 256B.692 for the
560.28 prepaid medical assistance program. The withheld funds must be returned no sooner than
560.29 July 1 and no later than July 31 of the following year. The commissioner may exclude
560.30 special demonstration projects under subdivision 23.

560.31 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
560.32 withhold three percent of managed care plan payments under this section and county-based
560.33 purchasing plan payments under section 256B.692 for the prepaid medical assistance
560.34 program. The withheld funds must be returned no sooner than July 1 and no later than July
561.1 31 of the following year. The commissioner may exclude special demonstration projects
561.2 under subdivision 23.

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

561.6 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
561.7 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
561.8 7.

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

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

561.22 **EFFECTIVE DATE.** This section is effective January 1, 2023.

561.23 Sec. 29. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

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

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

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

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

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

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

- 562.9 (1) tube feedings requiring:
- 562.10 (i) a gastrojejunostomy tube; or
- 562.11 (ii) continuous tube feeding lasting longer than 12 hours per day;
- 562.12 (2) wounds described as:
- 562.13 (i) stage III or stage IV;
- 562.14 (ii) multiple wounds;
- 562.15 (iii) requiring sterile or clean dressing changes or a wound vac; or
- 562.16 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized
- 562.17 care;
- 562.18 (3) parenteral therapy described as:
- 562.19 (i) IV therapy more than two times per week lasting longer than four hours for each
- 562.20 treatment; or
- 562.21 (ii) total parenteral nutrition (TPN) daily;
- 562.22 (4) respiratory interventions, including:
- 562.23 (i) oxygen required more than eight hours per day;
- 562.24 (ii) respiratory vest more than one time per day;
- 562.25 (iii) bronchial drainage treatments more than two times per day;
- 562.26 (iv) sterile or clean suctioning more than six times per day;
- 562.27 (v) dependence on another to apply respiratory ventilation augmentation devices such
- 562.28 as BiPAP and CPAP; and
- 562.29 (vi) ventilator dependence under section 256B.0651;
- 563.1 (5) insertion and maintenance of catheter, including:
- 563.2 (i) sterile catheter changes more than one time per month;
- 563.3 (ii) clean intermittent catheterization, and including self-catheterization more than six
- 563.4 times per day; or
- 563.5 (iii) bladder irrigations;
- 563.6 (6) bowel program more than two times per week requiring more than 30 minutes to
- 563.7 perform each time;
- 563.8 (7) neurological intervention, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

565.10 (u) "Participant's representative" means a parent, family member, advocate, or other
565.11 adult authorized by the participant or participant's legal representative, if any, to serve as a
565.12 representative in connection with the provision of CFSS. This authorization must be in
565.13 writing or by another method that clearly indicates the participant's free choice and may be
565.14 withdrawn at any time. The participant's representative must have no financial interest in
565.15 the provision of any services included in the participant's CFSS service delivery plan and
565.16 must be capable of providing the support necessary to assist the participant in the use of
565.17 CFSS. If through the assessment process described in subdivision 5 a participant is

565.18 determined to be in need of a participant's representative, one must be selected. If the
565.19 participant is unable to assist in the selection of a participant's representative, the legal
565.20 representative shall appoint one. Two persons may be designated as a participant's
565.21 representative for reasons such as divided households and court-ordered custodies. Duties
565.22 of a participant's representatives may include:

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

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

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

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

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

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

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

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

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

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

566.17 (cc) "Worker training and development" means services provided according to subdivision
566.18 18a for developing workers' skills as required by the participant's individual CFSS service
566.19 delivery plan that are arranged for or provided by the agency-provider or purchased by the
566.20 participant employer. These services include training, education, direct observation and

566.21 supervision, and evaluation and coaching of job skills and tasks, including supervision of
566.22 health-related tasks or behavioral supports.

566.23 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
566.24 whichever is later. The commissioner of human services must notify the revisor of statutes
566.25 when federal approval is obtained.

493.13 Sec. 45. Minnesota Statutes 2020, section 256B.85, subdivision 7a, is amended to read:

493.14 Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS
493.15 must be paid for services provided to persons who qualify for ~~12~~ ten or more hours of CFSS
493.16 per day when provided by a support worker who meets the requirements of subdivision 16,
493.17 paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate
493.18 adjustments implemented by the commissioner on July 1, 2019, to comply with the terms
493.19 of a collective bargaining agreement between the state of Minnesota and an exclusive
493.20 representative of individual providers under section 179A.54 that provides for wage increases
493.21 for individual providers who serve participants assessed to need 12 or more hours of CFSS
493.22 per day.

493.23 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
493.24 whichever occurs later. The commissioner shall notify the revisor of statutes when federal
493.25 approval is obtained.

493.26 Sec. 46. Minnesota Statutes 2020, section 256B.85, subdivision 16, is amended to read:

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

493.28 (1) enroll with the department as a support worker after a background study under chapter
493.29 245C has been completed and the support worker has received a notice from the
493.30 commissioner that the support worker:

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

494.1 (ii) is disqualified, but has received a set-aside of the disqualification under section
494.2 245C.22;

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

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

494.7 (4) complete the basic standardized CFSS training as determined by the commissioner
494.8 before completing enrollment. The training must be available in languages other than English
494.9 and to those who need accommodations due to disabilities. CFSS support worker training
494.10 must include successful completion of the following training components: basic first aid,
494.11 vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and

494.12 responsibilities of support workers including information about basic body mechanics,
494.13 emergency preparedness, orientation to positive behavioral practices, orientation to
494.14 responding to a mental health crisis, fraud issues, time cards and documentation, and an
494.15 overview of person-centered planning and self-direction. Upon completion of the training
494.16 components, the support worker must pass the certification test to provide assistance to
494.17 participants;

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

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

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

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

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

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

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

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

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

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

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

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

495.12 (1) provides services, within the scope of CFSS described in subdivision 7, to a participant
495.13 who qualifies for ~~12~~ ten or more hours per day of CFSS; and

495.14 (2) satisfies the current requirements of Medicare for training and competency or
495.15 competency evaluation of home health aides or nursing assistants, as provided in the Code

495.16 of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved
495.17 training or competency requirements.

495.18 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
495.19 whichever occurs later. The commissioner shall notify the revisor of statutes when federal
495.20 approval is obtained.

495.21 Sec. 47. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
495.22 to read:

495.23 Subd. 27. **Personal care assistance and community first services and supports**
495.24 **provider agency; required reporting and analysis of cost data.** (a) The commissioner
495.25 must evaluate on an ongoing basis whether the rates paid for personal care assistance and
495.26 community first services and supports appropriately address the costs to provide these
495.27 services. The commissioner must make recommendations to adjust the rates paid as indicated
495.28 by the evaluation. As determined by the commissioner, in consultation with stakeholders,
495.29 agencies enrolled to provide personal care assistance and community first services and
495.30 supports with rates determined under this section must submit requested cost data to the
495.31 commissioner. Requested cost data may include but is not limited to:

495.32 (1) worker wage costs;

496.1 (2) benefits paid;

496.2 (3) supervisor wage costs;

496.3 (4) executive wage costs;

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

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

496.6 (7) administrative costs paid;

496.7 (8) program costs paid;

496.8 (9) transportation costs paid;

496.9 (10) vacancy rates; and

496.10 (11) other data relating to costs necessary to provide services requested by the
496.11 commissioner.

496.12 (b) At least once in any three-year period, a provider must submit cost data for a fiscal
496.13 year that ended not more than 18 months prior to the submission date. The commissioner
496.14 shall give each provider notice 90 days prior to the submission due date. If a provider fails
496.15 to submit the required reporting data, the commissioner shall provide notice to the provider
496.16 30 days after the required submission date, and a second notice to a provider who fails to
496.17 submit the required data 60 days after the required submission date. The commissioner shall
496.18 temporarily suspend payments to a provider if the provider fails to submit cost data within

566.26 Sec. 30. [256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT
566.27 RATES.
566.28 Subdivision 1. Application. (a) The payment methodologies in this section apply to:
566.29 (1) community first services and supports (CFSS), extended CFSS, and enhanced rate
566.30 CFSS under section 256B.85; and
566.31 (2) personal care assistance services under section 256B.0625, subdivisions 19a and
566.32 19c; extended personal care assistance service as defined in section 256B.0659, subdivision

496.19 90 days after the required submission date. The commissioner shall make withheld payments
496.20 to the provider once the commissioner receives cost data from the provider.
496.21 (c) The commissioner shall conduct a random validation of data submitted under
496.22 paragraph (a) to ensure data accuracy.
496.23 (d) The commissioner, in consultation with stakeholders, shall develop and implement
496.24 a process for providing training and technical assistance necessary to support provider
496.25 submission of cost documentation required under paragraph (a). The commissioner shall
496.26 provide dedicated support for providers who meet one of the following criteria:
496.27 (1) the provider employs fewer than ten staff to provide the services under this section;
496.28 (2) the provider's first language is not English; or
496.29 (3) the provider serves a population that includes greater than or equal to 50 percent
496.30 black people, Indigenous people, or people of color.
497.1 Sec. 48. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision
497.2 to read:
497.3 Subd. 28. Payment rates evaluation. (a) The commissioner shall assess data collected
497.4 under subdivision 27 and shall publish evaluation findings in a report to the legislature on
497.5 August 1, 2024, and once every two years thereafter. Evaluation findings shall include:
497.6 (1) the costs that providers incur while providing services under this section;
497.7 (2) comparisons between those costs and the costs incurred by providers of comparable
497.8 services and employers in industries competing in the same labor market;
497.9 (3) changes in wages, benefits provided, hours worked, and retention over time; and
497.10 (4) recommendations for the rate methodologies paid based on the evaluation findings.
497.11 (b) The commissioner shall only release cost data in an aggregate form and shall not
497.12 release cost data from individual providers except as permitted by current law.
497.13 EFFECTIVE DATE. This section is effective July 1, 2021.

567.1 1; and enhanced rate personal care assistance services under section 256B.0659, subdivision
567.2 17a.

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

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

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

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

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

567.12 Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage
567.13 component values, the commissioner must use the Minnesota-specific median wage for the
567.14 standard occupational classification (SOC) codes published by the Bureau of Labor Statistics
567.15 in the edition of the Occupational Handbook available January 1, 2021. The commissioner
567.16 must calculate the base wage component values as follows for:

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

567.20 (2) enhanced rate personal care assistance services and enhanced rate CFSS. The base
567.21 wage component value equals the product of median wage for personal care aide (SOC
567.22 code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision
567.23 17a; and

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

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

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

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

568.6 (d) On August 1, 2024, and every two years thereafter, the commissioner shall report
568.7 recommendations to the chairs and ranking minority members of the legislative committees
568.8 and divisions with jurisdiction over health and human services policy and finance an update
568.9 of the competitive workforce factors in this subdivision using the most recently available
568.10 data. The commissioner shall make adjustments to the competitive workforce factor toward
568.11 the percent difference between: (1) the median wage for personal care aide (SOC code
568.12 31-1120); and (2) the weighted average wage for all other SOC codes with the same Bureau
568.13 of Labor Statistics classifications for education, experience, and training required for job
568.14 competency.

568.15 (e) The commissioner shall recommend an increase or decrease of the competitive
568.16 workforce factor from its previous value by no more than three percentage points. If, after
568.17 a biennial adjustment, the competitive workforce factor is less than or equal to zero, the
568.18 competitive workforce factor shall be zero.

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

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

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

568.23 (3) employee benefits factor, 12.04 percent;

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

568.25 (5) program plan support factor, 7.00 percent;

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

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

568.28 (8) absence and utilization factor, 3.90 percent.

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

568.31 (1) personal care assistance services and CFSS: 75.45 percent;

569.1 (2) enhanced rate personal care assistance services and enhanced rate CFSS: 75.45
569.2 percent; and

569.3 (3) qualified professional services and CFSS worker training and development: 75.45
569.4 percent.

569.5 Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine
569.6 the rate for personal care assistance services, CFSS, extended personal care assistance

569.7 services, extended CFSS, enhanced rate personal care assistance services, enhanced rate
569.8 CFSS, qualified professional services, and CFSS worker training and development as
569.9 follows:

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

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

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

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

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

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

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

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

569.29 (b) The commissioner must publish the total adjusted payment rates.

569.30 Subd. 7. **Personal care provider agency; required reporting and analysis of cost**
569.31 **data.** (a) The commissioner shall evaluate on an ongoing basis whether the base wage
569.32 component values and component values in this section appropriately address the cost to
570.1 provide the service. The commissioner shall make recommendations to adjust the rate
570.2 methodology as indicated by the evaluation. As determined by the commissioner and in
570.3 consultation with stakeholders, agencies enrolled to provide services with rates determined
570.4 under this section must submit requested cost data to the commissioner. The commissioner
570.5 may request cost data, including but not limited to:

570.6 (1) worker wage costs;

570.7 (2) benefits paid;

570.8 (3) supervisor wage costs;

570.9 (4) executive wage costs;
570.10 (5) vacation, sick, and training time paid;
570.11 (6) taxes, workers' compensation, and unemployment insurance costs paid;
570.12 (7) administrative costs paid;
570.13 (8) program costs paid;
570.14 (9) transportation costs paid;
570.15 (10) staff vacancy rates; and
570.16 (11) other data relating to costs required to provide services requested by the
570.17 commissioner.

570.18 (b) At least once in any three-year period, a provider must submit the required cost data
570.19 for a fiscal year that ended not more than 18 months prior to the submission date. The
570.20 commissioner must provide each provider a 90-day notice prior to its submission due date.
570.21 If a provider fails to submit required cost data, the commissioner must provide notice to a
570.22 provider that has not provided required cost data 30 days after the required submission date
570.23 and a second notice to a provider that has not provided required cost data 60 days after the
570.24 required submission date. The commissioner must temporarily suspend payments to a
570.25 provider if the commissioner has not received required cost data 90 days after the required
570.26 submission date. The commissioner must make withheld payments when the required cost
570.27 data is received by the commissioner.

570.28 (c) The commissioner must conduct a random validation of data submitted under this
570.29 subdivision to ensure data accuracy. The commissioner shall analyze cost documentation
570.30 in paragraph (a) and provide recommendations for adjustments to cost components.

571.1 (d) The commissioner shall analyze cost documentation in paragraph (a) and may submit
571.2 recommendations on component values, updated base wage component values, and
571.3 competitive workforce factors to the chair and ranking minority members of the legislative
571.4 committees and divisions with jurisdiction over human services policy and finance every
571.5 two years beginning August 1, 2026. The commissioner shall release cost data in an aggregate
571.6 form, and cost data from individual providers shall not be released except as provided for
571.7 in current law.

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

571.11 Subd. 8. **Payment rates; reports required.** (a) The commissioner must assess the
571.12 standard component values and publish evaluation findings and recommended changes to
571.13 the rate methodology in a report to the legislature by August 1, 2026.

571.14 (b) The commissioner must assess the long-term impacts of the rate methodology
571.15 implementation on staff providing services with rates determined under this section, including
571.16 but not limited to measuring changes in wages, benefits provided, hours worked, and
571.17 retention. The commissioner must publish evaluation findings in a report to the legislature
571.18 by August 1, 2028, and once every two years thereafter.

571.19 Subd. 9. **Self-directed services workforce.** Nothing in this section limits the
571.20 commissioner's authority over terms and conditions for individual providers in covered
571.21 programs as defined in section 256B.0711. The commissioner's authority over terms and
571.22 conditions for individual providers in covered programs remains subject to the state's
571.23 obligations to meet and negotiate under chapter 179A, as modified and made applicable to
571.24 individual providers under section 179A.54, and to agreements with any exclusive
571.25 representative of individual providers, as authorized by chapter 179A, as modified and made
571.26 applicable to individual providers under section 179A.54. A change in the rate for services
571.27 within the covered programs defined in section 256B.0711 does not constitute a change in
571.28 a term or condition for individual providers in covered programs and is not subject to the
571.29 state's obligation to meet and negotiate under chapter 179A, except that, notwithstanding
571.30 any other law to the contrary, the state shall meet and negotiate with the exclusive
571.31 representative of individual providers over wage and benefit increases made possible by
571.32 rate increases provided between January 1, 2023 and June 30, 2023. Any resulting tentative
571.33 agreement shall be submitted to the legislature to be accepted or rejected in accordance with
571.34 sections 3.855 and 179A.22.

572.1 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
572.2 whichever is later. The commissioner of human services must notify the revisor of statutes
572.3 when federal approval is obtained.

572.4 Sec. 31. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

572.5 Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall
572.6 not enter into agreements for new housing support beds with total rates in excess of the
572.7 MSA equivalent rate except:

572.8 (1) for establishments licensed under chapter 245D provided the facility is needed to
572.9 meet the census reduction targets for persons with developmental disabilities at regional
572.10 treatment centers;

572.11 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
572.12 provide housing for chronic inebriates who are repetitive users of detoxification centers and
572.13 are refused placement in emergency shelters because of their state of intoxication, and
572.14 planning for the specialized facility must have been initiated before July 1, 1991, in
572.15 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
572.16 subdivision 20a, paragraph (b);

572.17 (3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ 500 supportive
572.18 housing units in Anoka, Carver, Dakota, Hennepin, ~~or Ramsey, Scott, or Washington~~ County

497.14 Sec. 49. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

497.15 Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall
497.16 not enter into agreements for new housing support beds with total rates in excess of the
497.17 MSA equivalent rate except:

497.18 (1) for establishments licensed under chapter 245D provided the facility is needed to
497.19 meet the census reduction targets for persons with developmental disabilities at regional
497.20 treatment centers;

497.21 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
497.22 provide housing for chronic inebriates who are repetitive users of detoxification centers and
497.23 are refused placement in emergency shelters because of their state of intoxication, and
497.24 planning for the specialized facility must have been initiated before July 1, 1991, in
497.25 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
497.26 subdivision 20a, paragraph (b);

497.27 (3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ supportive housing
497.28 units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental

572.19 for homeless adults with a mental illness, a history of substance abuse, or human
572.20 immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this
572.21 section, "homeless adult" means a person who is living on the street or in a shelter ~~or~~
572.22 ~~discharged from a regional treatment center, community hospital, or residential treatment~~
572.23 ~~program and~~, has no appropriate housing available, and lacks the resources and support
572.24 necessary to access appropriate housing. ~~At least 70 percent of the supportive housing units~~
572.25 ~~must serve homeless adults with mental illness, substance abuse problems, or human~~
572.26 ~~immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or,~~
572.27 ~~within the previous six months, have been discharged from a regional treatment center, or~~
572.28 ~~a state-contracted psychiatric bed in a community hospital, or a residential mental health~~
572.29 ~~or chemical dependency treatment program.~~ If a person meets the requirements of subdivision
572.30 1, paragraph (a) ~~or (b)~~, and receives a federal or state housing subsidy, the housing support
572.31 rate for that person is limited to the supplementary rate under section 256I.05, subdivision
572.32 1a, ~~and is determined by subtracting the amount of the person's countable income that~~
572.33 ~~exceeds the MSA equivalent rate from the housing support supplementary service rate.~~ A
572.34 resident in a demonstration project site who no longer participates in the demonstration
573.1 program shall retain eligibility for a housing support payment in an amount determined
573.2 under section 256I.06, subdivision 8, using the MSA equivalent rate. ~~Service funding under~~
573.3 ~~section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are~~
573.4 ~~available and the services can be provided through a managed care entity. If federal matching~~
573.5 ~~funds are not available, then service funding will continue under section 256I.05, subdivision~~
573.6 ~~1a;~~

573.7 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
573.8 Hennepin County providing services for recovering and chemically dependent men that has
573.9 had a housing support contract with the county and has been licensed as a board and lodge
573.10 facility with special services since 1980;

573.11 (5) for a housing support provider located in the city of St. Cloud, or a county contiguous
573.12 to the city of St. Cloud, that operates a 40-bed facility, that received financing through the
573.13 Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves
573.14 chemically dependent clientele, providing 24-hour-a-day supervision;

573.15 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
573.16 persons, operated by a housing support provider that currently operates a 304-bed facility
573.17 in Minneapolis, and a 44-bed facility in Duluth;

573.18 (7) for a housing support provider that operates two ten-bed facilities, one located in
573.19 Hennepin County and one located in Ramsey County, that provide community support and
573.20 24-hour-a-day supervision to serve the mental health needs of individuals who have
573.21 chronically lived unsheltered; ~~and~~

573.22 (8) for a facility authorized for recipients of housing support in Hennepin County with
573.23 a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility
573.24 and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

497.29 illness, a history of substance abuse, or human immunodeficiency virus or acquired
497.30 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person
497.31 who is living on the street or in a shelter ~~or discharged from a regional treatment center,~~
497.32 ~~community hospital, or residential treatment program and~~ has no appropriate housing
498.1 available and lacks the resources and support necessary to access appropriate housing. ~~At~~
498.2 ~~least 70 percent of the supportive housing units must serve homeless adults with mental~~
498.3 ~~illness, substance abuse problems, or human immunodeficiency virus or acquired~~
498.4 ~~immunodeficiency syndrome who are about to be or, within the previous six months, have~~
498.5 ~~been discharged from a regional treatment center, or a state-contracted psychiatric bed in~~
498.6 ~~a community hospital, or a residential mental health or chemical dependency treatment~~
498.7 ~~program.~~ If a person meets the requirements of subdivision 1, paragraph (a), and receives
498.8 a federal or state housing subsidy, the housing support rate for that person is limited to the
498.9 supplementary rate under section 256I.05, subdivision 1a, ~~and is determined by subtracting~~
498.10 ~~the amount of the person's countable income that exceeds the MSA equivalent rate from~~
498.11 ~~the housing support supplementary service rate.~~ A resident in a demonstration project site
498.12 who no longer participates in the demonstration program shall retain eligibility for a housing
498.13 support payment in an amount determined under section 256I.06, subdivision 8, using the
498.14 MSA equivalent rate. ~~Service funding under section 256I.05, subdivision 1a, will end June~~
498.15 ~~30, 1997, if federal matching funds are available and the services can be provided through~~
498.16 ~~a managed care entity. If federal matching funds are not available, then service funding will~~
498.17 ~~continue under section 256I.05, subdivision 1a;~~

498.18 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
498.19 Hennepin County providing services for recovering and chemically dependent men that has
498.20 had a housing support contract with the county and has been licensed as a board and lodge
498.21 facility with special services since 1980;

498.22 (5) for a housing support provider located in the city of St. Cloud, or a county contiguous
498.23 to the city of St. Cloud, that operates a 40-bed facility, that received financing through the
498.24 Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves
498.25 chemically dependent clientele, providing 24-hour-a-day supervision;

498.26 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
498.27 persons, operated by a housing support provider that currently operates a 304-bed facility
498.28 in Minneapolis, and a 44-bed facility in Duluth;

498.29 (7) for a housing support provider that operates two ten-bed facilities, one located in
498.30 Hennepin County and one located in Ramsey County, that provide community support and
498.31 24-hour-a-day supervision to serve the mental health needs of individuals who have
498.32 chronically lived unsheltered; ~~and~~

498.33 (8) for a facility authorized for recipients of housing support in Hennepin County with
498.34 a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility

573.25 (b) An agency may enter into a housing support agreement for beds with rates in excess
573.26 of the MSA equivalent rate in addition to those currently covered under a housing support
573.27 agreement if the additional beds are only a replacement of beds with rates in excess of the
573.28 MSA equivalent rate which have been made available due to closure of a setting, a change
573.29 of licensure or certification which removes the beds from housing support payment, or as
573.30 a result of the downsizing of a setting authorized for recipients of housing support. The
573.31 transfer of available beds from one agency to another can only occur by the agreement of
573.32 both agencies.

573.33 (c) The appropriation for this subdivision must include administrative funding equal to
573.34 the cost of two full-time equivalent employees to process eligibility. The commissioner
574.1 must disburse administrative funding to the fiscal agent for the counties under this
574.2 subdivision.

574.3 Sec. 32. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

574.4 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
574.5 subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed \$426.37 for other
574.6 services necessary to provide room and board if the residence is licensed by or registered
574.7 by the Department of Health, or licensed by the Department of Human Services to provide
574.8 services in addition to room and board, and if the provider of services is not also concurrently
574.9 receiving funding for services for a recipient under a home and community-based waiver
574.10 under title XIX of the federal Social Security Act; or funding from the medical assistance
574.11 program under section 256B.0659, for personal care services for residents in the setting; or
574.12 residing in a setting which receives funding under section 245.73. If funding is available
574.13 for other necessary services through a home and community-based waiver, or personal care
574.14 services under section 256B.0659, then the housing support rate is limited to the rate set in
574.15 subdivision 1. Unless otherwise provided in law, in no case may the supplementary service

499.1 and that until August 1, 2007, operated as a licensed chemical dependency treatment
499.2 program;

499.3 (9) for an additional 42 beds, resulting in a total of 54 beds, for a recovery community
499.4 organization and housing support provider that currently operates a 38-bed facility in Olmsted
499.5 County serving individuals diagnosed with substance use disorder, originally licensed and
499.6 registered by the Department of Health under section 157.17 in 2019, and will operate a
499.7 new 14-bed facility in Olmsted County serving individuals diagnosed with substance use
499.8 disorder; and

499.9 (10) for 46 beds for a recovery community organization and housing support provider
499.10 that as of March 1, 2021, operates three facilities in Blue Earth County licensed and registered
499.11 by the Department of Health under section 157.17, serving individuals diagnosed with
499.12 substance use disorder.

499.13 (b) An agency may enter into a housing support agreement for beds with rates in excess
499.14 of the MSA equivalent rate in addition to those currently covered under a housing support
499.15 agreement if the additional beds are only a replacement of beds with rates in excess of the
499.16 MSA equivalent rate which have been made available due to closure of a setting, a change
499.17 of licensure or certification which removes the beds from housing support payment, or as
499.18 a result of the downsizing of a setting authorized for recipients of housing support. The
499.19 transfer of available beds from one agency to another can only occur by the agreement of
499.20 both agencies.

499.21 **EFFECTIVE DATE.** This section is effective July 1, 2021.

499.22 Sec. 50. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

499.23 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
499.24 subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed \$426.37 for other
499.25 services necessary to provide room and board if the residence is licensed by or registered
499.26 by the Department of Health, or licensed by the Department of Human Services to provide
499.27 services in addition to room and board, and if the provider of services is not also concurrently
499.28 receiving funding for services for a recipient under a home and community-based waiver
499.29 under title XIX of the federal Social Security Act; or funding from the medical assistance
499.30 program under section 256B.0659, for personal care services for residents in the setting; or
499.31 residing in a setting which receives funding under section 245.73. If funding is available
499.32 for other necessary services through a home and community-based waiver, or personal care
499.33 services under section 256B.0659, then the housing support rate is limited to the rate set in
499.34 subdivision 1. Unless otherwise provided in law, in no case may the supplementary service

574.16 rate exceed \$426.37. The registration and licensure requirement does not apply to
574.17 establishments which are exempt from state licensure because they are located on Indian
574.18 reservations and for which the tribe has prescribed health and safety requirements. Service
574.19 payments under this section may be prohibited under rules to prevent the supplanting of
574.20 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining
574.21 the approval of the Secretary of Health and Human Services to provide home and
574.22 community-based waiver services under title XIX of the federal Social Security Act for
574.23 residents who are not eligible for an existing home and community-based waiver due to a
574.24 primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if
574.25 it is determined to be cost-effective.

574.26 (b) The commissioner is authorized to make cost-neutral transfers from the housing
574.27 support fund for beds under this section to other funding programs administered by the
574.28 department after consultation with the ~~county or counties~~ agency in which the affected beds
574.29 are located. The commissioner may also make cost-neutral transfers from the housing support
574.30 fund to ~~county human service~~ agencies for beds permanently removed from the housing
574.31 support census under a plan submitted by the ~~county~~ agency and approved by the
574.32 commissioner. The commissioner shall report the amount of any transfers under this provision
574.33 annually to the legislature.

575.1 (c) Counties Agencies must not negotiate supplementary service rates with providers of
575.2 housing support that are licensed as board and lodging with special services and that do not
575.3 encourage a policy of sobriety on their premises and make referrals to available community
575.4 services for volunteer and employment opportunities for residents.

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

575.6 Sec. 33. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

575.7 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
575.8 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

575.9 (a) An agency may increase the rates for room and board to the MSA equivalent rate
575.10 for those settings whose current rate is below the MSA equivalent rate.

575.11 (b) An agency may increase the rates for residents in adult foster care whose difficulty
575.12 of care has increased. The total housing support rate for these residents must not exceed the
575.13 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
575.14 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
575.15 by home and community-based waiver programs under title XIX of the Social Security Act.

575.16 (c) ~~The~~ room and board rates will be increased each year when the MSA equivalent rate
575.17 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
575.18 the amount of the increase in the medical assistance personal needs allowance under section
575.19 256B.35.

500.1 rate exceed \$426.37. The registration and licensure requirement does not apply to
500.2 establishments which are exempt from state licensure because they are located on Indian
500.3 reservations and for which the tribe has prescribed health and safety requirements. Service
500.4 payments under this section may be prohibited under rules to prevent the supplanting of
500.5 federal funds with state funds. The commissioner shall pursue the feasibility of obtaining
500.6 the approval of the Secretary of Health and Human Services to provide home and
500.7 community-based waiver services under title XIX of the federal Social Security Act for
500.8 residents who are not eligible for an existing home and community-based waiver due to a
500.9 primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if
500.10 it is determined to be cost-effective.

500.11 (b) The commissioner is authorized to make cost-neutral transfers from the housing
500.12 support fund for beds under this section to other funding programs administered by the
500.13 department after consultation with the ~~county or counties~~ agency in which the affected beds
500.14 are located. The commissioner may also make cost-neutral transfers from the housing support
500.15 fund to ~~county human service~~ agencies for beds permanently removed from the housing
500.16 support census under a plan submitted by the ~~county~~ agency and approved by the
500.17 commissioner. The commissioner shall report the amount of any transfers under this provision
500.18 annually to the legislature.

500.19 (c) Counties Agencies must not negotiate supplementary service rates with providers of
500.20 housing support that are licensed as board and lodging with special services and that do not
500.21 encourage a policy of sobriety on their premises and make referrals to available community
500.22 services for volunteer and employment opportunities for residents.

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

500.24 Sec. 51. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

500.25 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
500.26 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

500.27 (a) An agency may increase the rates for room and board to the MSA equivalent rate
500.28 for those settings whose current rate is below the MSA equivalent rate.

500.29 (b) An agency may increase the rates for residents in adult foster care whose difficulty
500.30 of care has increased. The total housing support rate for these residents must not exceed the
500.31 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
500.32 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
500.33 by home and community-based waiver programs under title XIX of the Social Security Act.

501.1 (c) An agency must increase the room and board rates ~~will be increased~~ each year when
501.2 the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the
501.3 annual SSI increase, less the amount of the increase in the medical assistance personal needs
501.4 allowance under section 256B.35.

575.20 (d) When housing support pays for an individual's room and board, or other costs
575.21 necessary to provide room and board, the rate payable to the residence must continue for
575.22 up to 18 calendar days per incident that the person is temporarily absent from the residence,
575.23 not to exceed 60 days in a calendar year, if the absence or absences are reported in advance
575.24 to the county agency's social service staff. Advance reporting is not required for emergency
575.25 absences due to crisis, illness, or injury. For purposes of maintaining housing while
575.26 temporarily absent due to residential behavioral health treatment or health care treatment
575.27 that requires admission to an inpatient hospital, nursing facility, or other health care facility,
575.28 the room and board rate for an individual is payable beyond an 18-calendar-day absence
575.29 period, not to exceed 150 days in a calendar year.

575.30 (e) For facilities meeting substantial change criteria within the prior year. Substantial
575.31 change criteria ~~exists~~ if the establishment experiences a 25 percent increase or decrease in
575.32 the total number of its beds, if the net cost of capital additions or improvements is in excess
575.33 of 15 percent of the current market value of the residence, or if the residence physically
576.1 moves, or changes its licensure, and incurs a resulting increase in operation and property
576.2 costs.

576.3 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
576.4 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
576.5 reside in residences that are licensed by the commissioner of health as a boarding care home,
576.6 but are not certified for the purposes of the medical assistance program. However, an increase
576.7 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
576.8 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
576.9 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
576.10 9549.0058.

501.5 (d) When housing support pays for an individual's room and board, or other costs
501.6 necessary to provide room and board, the rate payable to the residence must continue for
501.7 up to 18 calendar days per incident that the person is temporarily absent from the residence,
501.8 not to exceed 60 days in a calendar year, if the absence or absences are reported in advance
501.9 to the county agency's social service staff. Advance reporting is not required for emergency
501.10 absences due to crisis, illness, or injury.

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501.11 ~~(e)~~ For An agency may increase the rates for residents in facilities meeting substantial
501.12 change criteria within the prior year. Substantial change criteria ~~exists~~ exist if the
501.13 establishment experiences a 25 percent increase or decrease in the total number of its beds,
501.14 if the net cost of capital additions or improvements is in excess of 15 percent of the current
501.15 market value of the residence, or if the residence physically moves, or changes its licensure,
501.16 and incurs a resulting increase in operation and property costs.

501.17 ~~(f)~~ (e) Until June 30, 1994, an agency may increase by up to five percent the total rate
501.18 paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54
501.19 who reside in residences that are licensed by the commissioner of health as a boarding care
501.20 home, but are not certified for the purposes of the medical assistance program. However,
501.21 an increase under this clause must not exceed an amount equivalent to 65 percent of the
501.22 1991 medical assistance reimbursement rate for nursing home resident class A, in the
501.23 geographic grouping in which the facility is located, as established under Minnesota Rules,
501.24 parts 9549.0051 to 9549.0058.

501.25 (f) Notwithstanding the provisions of subdivision 1, an agency may increase the monthly
501.26 room and board rates by \$100 per month for residents in settings under section 256I.04,
501.27 subdivision 2a, paragraph (b), clause (2). Participants in the Minnesota supportive housing
501.28 demonstration program under section 256I.04, subdivision 3, paragraph (a), clause (3), may
501.29 not receive the increase under this paragraph.

501.30 **EFFECTIVE DATE.** This section is effective July 1, 2022, except the striking of
501.31 paragraph (d) is effective July 1, 2021.

502.1 Sec. 52. Minnesota Statutes 2020, section 256I.05, subdivision 1q, is amended to read:

502.2 Subd. 1q. **Supplemental rate; Olmsted County.** (a) Notwithstanding the provisions of
502.3 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a
502.4 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$750 per
502.5 month, including any legislatively authorized inflationary adjustments, for a housing support
502.6 provider located in Olmsted County that operates long-term residential facilities with a total
502.7 of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day
502.8 supervision and other support services.

502.9 (b) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021,
502.10 a county agency shall negotiate a supplemental service rate for 54 total beds in addition to
502.11 the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
502.12 1a, including any legislatively authorized inflationary adjustments, for a recovery community
502.13 organization and housing support provider located in Olmsted County serving individuals
502.14 diagnosed with substance use disorder, originally licensed and registered by the Department
502.15 of Health under section 157.17 in 2019.

502.16 Sec. 53. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision
502.17 to read:

502.18 Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding subdivisions 1a and
502.19 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental rate for up to
502.20 20 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate
502.21 allowed under subdivision 1a, including any legislatively authorized inflationary adjustments,
502.22 for a housing support provider located in Douglas County that operates two facilities and
502.23 provides room and board and supplementary services to adult males recovering from
502.24 substance use disorder, mental illness, or housing instability.

502.25 Sec. 54. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision
502.26 to read:

502.27 Subd. 1t. **Supplementary services rate; Winona County.** Notwithstanding the
502.28 provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate
502.29 a supplementary services rate in addition to the monthly room and board rate specified in
502.30 subdivision 1, not to exceed \$750 per month, including any legislatively authorized
502.31 inflationary adjustments, for a housing support provider located in Winona County that
502.32 operates a permanent supportive housing facility with 20 one-bedroom apartments for adults
502.33 with long-term homeless and long-term mental health needs.

503.1 Sec. 55. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision
503.2 to read:

503.3 Subd. 1u. **Supplemental rate; Blue Earth County.** Notwithstanding the provisions of
503.4 subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a
503.5 supplemental service rate for 46 beds in addition to the rate specified in subdivision 1, not
503.6 to exceed the maximum rate allowed under subdivision 1a, including any legislatively
503.7 authorized inflationary adjustments, for a recovery community organization and housing
503.8 support provider that as of March 1, 2021, operates three facilities in Blue Earth County
503.9 licensed and registered by the Department of Health under section 157.17, serving individuals
503.10 diagnosed with substance use disorder.

503.11 Sec. 56. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision
503.12 to read:

503.13 Subd. 1v. **Supplementary services rate; Steele County.** Notwithstanding the provisions
503.14 of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a

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576.11 Sec. 34. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

576.12 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
576.13 cost-neutral transfer of funding from the housing support fund to ~~county human service~~
576.14 ~~agencies~~ the agency for emergency shelter beds removed from the housing support census
576.15 under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner.
576.16 The plan must describe: (1) anticipated and actual outcomes for persons experiencing
576.17 homelessness in emergency shelters; (2) improved efficiencies in administration; (3)
576.18 requirements for individual eligibility; and (4) plans for quality assurance monitoring and
576.19 quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to
576.20 monitor implementation and outcomes at least biennially, and more frequently if the
576.21 commissioner deems necessary.

576.22 (b) The funding under paragraph (a) may be used for the provision of room and board
576.23 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
576.24 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated
576.25 annually, and the room and board portion of the allocation shall be adjusted according to
576.26 the percentage change in the housing support room and board rate. The room and board

503.15 supplementary services rate in addition to the monthly room and board rate specified in
503.16 subdivision 1, not to exceed \$750 per month, including any legislatively authorized
503.17 inflationary adjustments, for a housing support provider located in Steele County that
503.18 operates a permanent supportive housing facility with 16 units for adults with long-term
503.19 homeless and long-term mental health needs.

503.20 Sec. 57. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision
503.21 to read:

503.22 Subd. 2a. **Absent days.** (a) When a person receiving housing support is temporarily
503.23 absent and the absence is reported in advance to the agency's social service staff, the agency
503.24 must continue to pay on behalf of the person the applicable rate for housing support. Advance
503.25 reporting is not required for absences due to crisis, illness, or injury. The limit on payments
503.26 for absence days under this paragraph is 18 calendar days per incident, not to exceed 60
503.27 days in a calendar year.

503.28 (b) An agency must continue to pay an additional 74 days per incident, not to exceed a
503.29 total of 92 days in a calendar year, for a person who is temporarily absent due to admission
503.30 at a residential behavioral health facility, inpatient hospital, or nursing facility.

503.31 (c) If a person is temporarily absent due to admission at a residential behavioral health
503.32 facility, inpatient hospital, or nursing facility for a period of time exceeding the limits
503.33 described in paragraph (b), the agency may request in a format prescribed by the
504.1 commissioner an absence day limit exception to continue housing support payments until
504.2 the person is discharged.

504.3 **EFFECTIVE DATE.** This section is effective July 1, 2021.

504.4 Sec. 58. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

504.5 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
504.6 cost-neutral transfer of funding from the housing support fund to ~~county human service~~
504.7 ~~agencies~~ the agency for emergency shelter beds removed from the housing support census
504.8 under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner.
504.9 The plan must describe: (1) anticipated and actual outcomes for persons experiencing
504.10 homelessness in emergency shelters; (2) improved efficiencies in administration; (3)
504.11 requirements for individual eligibility; and (4) plans for quality assurance monitoring and
504.12 quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to
504.13 monitor implementation and outcomes at least biennially, and more frequently if the
504.14 commissioner deems necessary.

504.15 (b) The funding under paragraph (a) may be used for the provision of room and board
504.16 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
504.17 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated
504.18 annually, and the room and board portion of the allocation shall be adjusted according to
504.19 the percentage change in the housing support room and board rate. The room and board

576.27 portion of the allocation shall be determined at the time of transfer. The commissioner or
576.28 ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including
576.29 financial reconciliation.

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

576.31 Sec. 35. Minnesota Statutes 2020, section 256S.18, subdivision 7, is amended to read:

576.32 Subd. 7. **Monthly case mix budget cap exception.** The commissioner shall approve an
576.33 exception to the monthly case mix budget cap in ~~paragraph (a)~~ subdivision 3 to account for
577.1 the additional cost of providing enhanced rate personal care assistance services under section
577.2 256B.0659 or enhanced rate community first services and supports under section 256B.85.
577.3 ~~The exception shall not exceed 107.5 percent of the budget otherwise available to the~~
577.4 ~~individual.~~ The commissioner must calculate the difference between the rate for personal
577.5 care assistance services and enhanced rate personal care assistance services. The additional
577.6 budget amount approved under an exception must not exceed this difference. The exception
577.7 must be reapproved on an annual basis at the time of a participant's annual reassessment.

577.8 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
577.9 whichever is later. The commissioner of human services must notify the revisor of statutes
577.10 when federal approval is obtained.

577.11 Sec. 36. Minnesota Statutes 2020, section 256S.20, subdivision 1, is amended to read:

577.12 Subdivision 1. **Customized living services provider requirements.** ~~Only a provider~~
577.13 ~~licensed by the Department of Health as a comprehensive home care provider may provide~~

504.20 portion of the allocation shall be determined at the time of transfer. The commissioner or
504.21 ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including
504.22 financial reconciliation.

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

504.24 Sec. 59. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

504.25 Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board
504.26 payment to be made on behalf of an eligible individual is determined by subtracting the
504.27 individual's countable income under section 256I.04, subdivision 1, for a whole calendar
504.28 month from the room and board rate for that same month. The housing support payment is
504.29 determined by multiplying the housing support rate times the period of time the individual
504.30 was a resident or temporarily absent under section 256I.05, subdivision 1e, ~~paragraph (d)~~
504.31 ~~2a.~~

505.1 (b) For an individual with earned income under paragraph (a), prospective budgeting
505.2 must be used to determine the amount of the individual's payment for the following six-month
505.3 period. An increase in income shall not affect an individual's eligibility or payment amount
505.4 until the month following the reporting month. A decrease in income shall be effective the
505.5 first day of the month after the month in which the decrease is reported.

505.6 (c) For an individual who receives housing support payments under section 256I.04,
505.7 subdivision 1, paragraph (c), the amount of the housing support payment is determined by
505.8 multiplying the housing support rate times the period of time the individual was a resident.

505.9 **EFFECTIVE DATE.** This section is effective July 1, 2021.

577.14 (a) To deliver customized living services or 24-hour customized living services, a provider
577.15 must:

577.16 (1) be licensed as an assisted living facility under chapter 144G; or

577.17 (2) be licensed as a comprehensive home care provider under chapter 144A and be
577.18 delivering services: (i) in a setting defined under section 144G.08, subdivision 7, clauses
577.19 (11) to (13); or (ii) in an affordable housing setting under section 144G.08, subdivision 7,
577.20 clause (10), that is delivering authorized customized living services to a person in the setting
577.21 on or before June 30, 2022. A licensed home care provider is subject to section 256B.0651,
577.22 subdivision 14.

577.23 (b) Settings under paragraph (a), clause (2), must comply with section 256S.2003.

577.24 **EFFECTIVE DATE.** This section is effective August 1, 2021.

577.25 Sec. 37. **[256S.2003] CUSTOMIZED LIVING SERVICES; REQUIREMENTS OF**
577.26 **PROVIDERS IN DESIGNATED SETTINGS.**

577.27 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
577.28 the meanings given.

577.29 (b) "Designated provider" means a home care provider licensed under chapter 144A that
577.30 provides customized living services to some or all of the residents of a designated setting
577.31 and that is either the setting itself or another entity with which the setting has a contract or
577.32 business relationship.

578.1 (c) "Designated setting" means a setting defined under section 256S.20, subdivision 1,
578.2 paragraph (a), clause (2).

578.3 (d) "Resident" means a person receiving customized living services in a designated
578.4 setting.

578.5 Subd. 2. **Attestation of compliance with requirements.** Upon enrollment with the
578.6 department to provide customized living services, a designated provider of customized
578.7 living services must submit an attestation that the provider is in compliance with subdivisions
578.8 3 to 8.

578.9 Subd. 3. **Contracts.** (a) Every designated provider must execute a written contract with
578.10 a resident or the resident's representative and must operate in accordance with the terms of
578.11 the contract. The resident or the resident's representative must be given a complete copy of
578.12 the contract and all supporting documents and attachments and any changes whenever
578.13 changes are made.

578.14 (b) The contract must include at least the following elements in itself or through
578.15 supporting documents or attachments:

578.16 (1) the name, street address, and mailing address of the designated provider;

- 578.17 (2) the name and mailing address of the owner or owners of the designated provider
578.18 and, if the owner or owners are not natural persons, identification of the type of business
578.19 entity of the owner or owners;
- 578.20 (3) the name and mailing address of the managing agent, through management agreement
578.21 or lease agreement, of the designated provider, if different from the owner or owners;
- 578.22 (4) the name and address of at least one natural person who is authorized to accept service
578.23 of process on behalf of the owner or owners and managing agent;
- 578.24 (5) a statement identifying the designated provider's home care license number;
- 578.25 (6) the term of the contract;
- 578.26 (7) an itemization and description of the services to be provided to the resident;
- 578.27 (8) a conspicuous notice informing the resident of the policy concerning the conditions
578.28 under which and the process through which the contract may be modified, amended, or
578.29 terminated;
- 578.30 (9) a description of the designated provider's complaint resolution process available to
578.31 residents including the toll-free complaint line for the Office of Ombudsman for Long-Term
578.32 Care;
- 579.1 (10) the resident's designated representative, if any;
- 579.2 (11) the designated provider's referral procedures if the contract is terminated;
- 579.3 (12) a statement regarding the ability of a resident to receive services from service
579.4 providers with whom the designated provider does not have an arrangement;
- 579.5 (13) a statement regarding the availability of public funds for payment for residence or
579.6 services; and
- 579.7 (14) a statement regarding the availability of and contact information for long-term care
579.8 consultation services under section 256B.0911 in the county in which the establishment is
579.9 located.
- 579.10 (c) The contract must include a statement regarding:
- 579.11 (1) the ability of a resident to furnish and decorate the resident's unit within the terms
579.12 of the lease;
- 579.13 (2) a resident's right to access food at any time;
- 579.14 (3) a resident's right to choose the resident's visitors and times of visits;
- 579.15 (4) a resident's right to choose a roommate if sharing a unit; and
- 579.16 (5) a resident's right to have and use a lockable door to the resident's unit. The designated
579.17 setting must provide the locks on the unit. Only a staff member with a specific need to enter

579.18 the unit shall have keys, and advance notice must be given to the resident before entrance,
579.19 when possible.

579.20 (d) A restriction of a resident's rights under this subdivision is allowed only if determined
579.21 necessary for health and safety reasons identified by the home care provider's registered
579.22 nurse in an initial assessment or reassessment, as defined under section 144A.4791,
579.23 subdivision 8, and documented in the written service plan under section 144A.4791,
579.24 subdivision 9. Any restrictions of those rights for people served under this chapter and
579.25 section 256B.49 must be documented in the resident's coordinated service and support plan,
579.26 as defined under sections 256B.49, subdivision 15, and 256S.10.

579.27 (e) The contract and related documents executed by each resident or resident's
579.28 representative must be maintained by the designated provider in files from the date of
579.29 execution until three years after the contract is terminated.

579.30 Subd. 4. **Training in dementia.** (a) If a designated provider has a special program or
579.31 special care unit for residents with Alzheimer's disease or other dementias or advertises,
579.32 markets, or otherwise promotes the provision of services for persons with Alzheimer's
580.1 disease or other dementias, whether in a segregated or general unit, employees of the provider
580.2 must meet the following training requirements:

580.3 (1) supervisors of direct-care staff must have at least eight hours of initial training on
580.4 topics specified under paragraph (b) within 120 working hours of the employment start
580.5 date, and must have at least two hours of training on topics related to dementia care for each
580.6 12 months of employment thereafter;

580.7 (2) direct-care employees must have completed at least eight hours of initial training on
580.8 topics specified under paragraph (b) within 160 working hours of the employment start
580.9 date. Until this initial training is complete, an employee must not provide direct care unless
580.10 there is another employee on site who has completed the initial eight hours of training on
580.11 topics related to dementia care and who can act as a resource and assist if issues arise. A
580.12 trainer of the requirements under paragraph (b), or a supervisor meeting the requirements
580.13 in clause (1), must be available for consultation with the new employee until the training
580.14 requirement is complete. Direct-care employees must have at least two hours of training on
580.15 topics related to dementia care for each 12 months of employment thereafter;

580.16 (3) staff who do not provide direct care, including maintenance, housekeeping, and food
580.17 service staff, must have at least four hours of initial training on topics specified under
580.18 paragraph (b) within 160 working hours of the employment start date, and must have at
580.19 least two hours of training on topics related to dementia care for each 12 months of
580.20 employment thereafter; and

580.21 (4) new employees may satisfy the initial training requirements under clauses (1) to (3)
580.22 by producing written proof of previously completed required training within the past 18
580.23 months.

- 580.24 (b) Areas of required training include:
- 580.25 (1) an explanation of Alzheimer's disease and related disorders;
- 580.26 (2) assistance with activities of daily living;
- 580.27 (3) problem solving with challenging behaviors; and
- 580.28 (4) communication skills.
- 580.29 (c) The provider must provide to residents and prospective residents in written or
- 580.30 electronic form a description of the training program, the categories of employees trained,
- 580.31 the frequency of training, and the basic topics covered.
- 581.1 Subd. 5. **Restraints.** Residents must be free from any physical or chemical restraints
- 581.2 imposed for purposes of discipline or convenience.
- 581.3 Subd. 6. **Termination of contract.** A designated provider must include with notice of
- 581.4 termination of contract information about how to contact the ombudsman for long-term
- 581.5 care, including the address and telephone number, along with a statement of how to request
- 581.6 problem-solving assistance.
- 581.7 Subd. 7. **Manager requirements.** (a) The person primarily responsible for oversight
- 581.8 and management of the designated provider, as designated by the owner, must obtain at
- 581.9 least 30 hours of continuing education every two years of employment as the manager in
- 581.10 topics relevant to the operations of the facility and the needs of its tenants. Continuing
- 581.11 education earned to maintain a professional license, such as a nursing home administrator
- 581.12 license, nursing license, social worker license, or real estate license, can be used to complete
- 581.13 this requirement.
- 581.14 (b) New managers may satisfy the initial dementia training requirements by producing
- 581.15 written proof of previously completed required training within the past 18 months.
- 581.16 Subd. 8. **Emergency planning.** (a) Each designated provider must meet the following
- 581.17 requirements:
- 581.18 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
- 581.19 elements of sheltering in-place, identifies temporary relocation sites, and details staff
- 581.20 assignments in the event of a disaster or an emergency;
- 581.21 (2) prominently post an emergency disaster plan;
- 581.22 (3) provide building emergency exit diagrams to all residents upon signing a contract;
- 581.23 (4) post emergency exit diagrams on each floor; and
- 581.24 (5) have a written policy and procedure regarding missing residents.
- 581.25 (b) Each designated provider must provide emergency and disaster training to all staff
- 581.26 during the initial staff orientation and annually thereafter and must make emergency and

581.27 disaster training available to all residents annually. Staff who have not received emergency
581.28 and disaster training are allowed to work only when trained staff are also working on site.

581.29 (c) Each designated provider location must conduct and document a fire drill or other
581.30 emergency drill at least once every six months. To the extent possible, drills must be
581.31 coordinated with local fire departments or other community emergency resources.

582.1 Subd. 9. **Other laws.** Each designated provider must comply with chapter 504B, and
582.2 must obtain and maintain all other licenses, permits, registrations, or other required
582.3 governmental approvals. A designated provider is not required to obtain a lodging license
582.4 under chapter 157 and related rules.

582.5 **EFFECTIVE DATE.** This section is effective August 1, 2021.

505.10 Sec. 60. Minnesota Statutes 2020, section 256S.203, is amended to read:

505.11 **256S.203 CUSTOMIZED LIVING SERVICES; MANAGED CARE RATES.**

505.12 Subdivision 1. **Capitation payments.** The commissioner ~~shall~~ must adjust the elderly
505.13 waiver capitation payment rates for managed care organizations paid to reflect the monthly
505.14 service rate limits for customized living services and 24-hour customized living services
505.15 established under section 256S.202 and the rate adjustments for disproportionate share
505.16 facilities under section 256S.205.

505.17 Subd. 2. **Reimbursement rates.** Medical assistance rates paid to customized living
505.18 providers by managed care organizations under this chapter ~~shall~~ must not exceed the
505.19 monthly service rate limits and component rates as determined by the commissioner under
505.20 sections 256S.15 and 256S.20 to 256S.202, plus any rate adjustment under section 256S.205.

505.21 Sec. 61. **256S.205] CUSTOMIZED LIVING SERVICES; DISPROPORTIONATE**
505.22 **SHARE RATE ADJUSTMENTS.**

505.23 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this
505.24 subdivision have the meanings given.

505.25 (b) "Application year" means a year in which a facility submits an application for
505.26 designation as a disproportionate share facility.

505.27 (c) "Assisted living facility" or "facility" means an assisted living facility licensed under
505.28 chapter 144G.

505.29 (d) "Disproportionate share facility" means an assisted living facility designated by the
505.30 commissioner under subdivision 4.

506.1 Subd. 2. **Rate adjustment application.** An assisted living facility may apply to the
506.2 commissioner for designation as a disproportionate share facility. Applications must be
506.3 submitted annually between October 1 and October 31. The applying facility must apply

506.4 in a manner determined by the commissioner. The applying facility must document as a
506.5 percentage the census of elderly waiver participants residing in the facility on October 1 of
506.6 the application year.

506.7 Subd. 3. **Rate adjustment eligibility criteria.** Only facilities with a census of at least
506.8 80 percent elderly waiver participants on October 1 of the application year are eligible for
506.9 designation as a disproportionate share facility.

506.10 Subd. 4. **Designation as a disproportionate share facility.** By November 15 of each
506.11 application year, the commissioner must designate as a disproportionate share facility a
506.12 facility that complies with the application requirements of subdivision 2 and meets the
506.13 eligibility criteria of subdivision 3.

506.14 Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized
506.15 living monthly service rate limits under section 256S.202, subdivision 2, and the component
506.16 service rates established under section 256S.201, subdivision 4, the commissioner must
506.17 establish a rate floor equal to \$119 per resident per day for 24-hour customized living
506.18 services provided in a designated disproportionate share facility for the purpose of ensuring
506.19 the minimal level of staffing required to meet the health and safety need of elderly waiver
506.20 participants.

506.21 (b) The commissioner must adjust the rate floor at least annually in the manner described
506.22 under section 256S.18, subdivisions 5 and 6.

506.23 (c) The commissioner shall not implement the rate floor under this section if the
506.24 customized living rates established under sections 256S.21 to 256S.215 will be implemented
506.25 at 100 percent on January 1 of the year following an application year.

506.26 Subd. 6. **Budget cap disregard.** The value of the rate adjustment under this section
506.27 must not be included in an elderly waiver client's monthly case mix budget cap.

506.28 **EFFECTIVE DATE.** This section is effective October 1, 2021, or upon federal approval,
506.29 whichever is later, and applies to services provided on or after January 1, 2022, or on or
506.30 after the date upon which federal approval is obtained, whichever is later. The commissioner
506.31 of human services shall notify the revisor of statutes when federal approval is obtained.

507.1 Sec. 62. Laws 2019, First Special Session chapter 9, article 5, section 86, subdivision 1,
507.2 as amended by Laws 2020, First Special Session chapter 2, article 3, section 2, subdivision
507.3 1, is amended to read:

507.4 Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance
507.5 waiver programs for people with disabilities to simplify administration of the programs.
507.6 Disability waiver reconfiguration must incentivize inclusive, person-centered, individualized
507.7 supports and services; enhance each person's self-determination and personal authority over
507.8 the person's service choice; align benefits across waivers; ensure equity across programs
507.9 and populations; assess and address racial and geographical disparities and institutional bias
507.10 in services and programs; promote long-term sustainability of waiver services; and maintain

582.6 Sec. 38. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

582.7 The labor agreement between the state of Minnesota and the Service Employees
582.8 International Union Healthcare Minnesota, submitted to the Legislative Coordinating
582.9 Commission on March 1, 2021, is ratified.

582.10 Sec. 39. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING**
582.11 **REPORT.**

582.12 (a) By January 15, 2022, the commissioner of human services shall submit a report to
582.13 the chairs and ranking minority members of the legislative committees with jurisdiction
582.14 over human services policy and finance. The report must include the commissioner's:

582.15 (1) assessment of the prevalence of customized living services provided under Minnesota
582.16 Statutes, section 256B.49, supplanting the provision of residential services and supports
582.17 licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under
582.18 Minnesota Statutes, chapter 245A;

582.19 (2) recommendations regarding the continuation of the moratorium on home and
582.20 community-based services customized living settings under Minnesota Statutes, section
582.21 256B.49, subdivision 28;

582.22 (3) other policy recommendations to ensure that customized living services are being
582.23 provided in a manner consistent with the policy objectives of the foster care licensing
582.24 moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

582.25 (4) recommendations for needed statutory changes to implement the transition from
582.26 existing four-person or fewer customized living settings to corporate adult foster care or
582.27 community residential settings.

582.28 (b) The commissioner of health shall provide the commissioner of human services with
582.29 the required data to complete the report in paragraph (a) and implement the moratorium on
582.30 home and community-based services customized living settings under Minnesota Statutes,
582.31 section 256B.49, subdivision 28. The data must include, at a minimum, each registered
582.32 housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as
583.1 a customized living setting to deliver customized living services as defined under the brain
583.2 injury or community access for disability inclusion waiver plans under Minnesota Statutes,
583.3 section 256B.49.

583.4 Sec. 40. **DIRECTION TO COMMISSIONER; PROVIDER STANDARDS FOR**
583.5 **CUSTOMIZED LIVING SERVICES IN DESIGNATED SETTINGS.**

583.6 The commissioner of human services shall review policies and provider standards for
583.7 customized living services provided in settings identified in Minnesota Statutes, section

507.11 service stability and continuity of care while prioritizing, promoting, and creating incentives
507.12 for independent, integrated, and individualized supports and services chosen by each person
507.13 through an informed decision-making process and person-centered planning.

510.23 Sec. 67. **DIRECTION TO COMMISSIONERS; CUSTOMIZED LIVING REPORT.**

510.24 (a) By January 15, 2022, the commissioner of human services shall submit a report to
510.25 the chairs and ranking minority members of the legislative committees with jurisdiction
510.26 over human services policy and finance. The report must include the commissioner's:

510.27 (1) assessment of the prevalence of customized living services provided under Minnesota
510.28 Statutes, section 256B.49, supplanting the provision of residential services and supports
510.29 licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under
510.30 Minnesota Statutes, chapter 245A;

511.1 (2) recommendations regarding the continuation of the moratorium on home and
511.2 community-based services customized living settings under Minnesota Statutes, section
511.3 256B.49, subdivision 28;

511.4 (3) other policy recommendations to ensure that customized living services are being
511.5 provided in a manner consistent with the policy objectives of the foster care licensing
511.6 moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

511.7 (4) recommendations for needed statutory changes to implement the transition from
511.8 existing four-person or fewer customized living settings to corporate adult foster care or
511.9 community residential settings.

511.10 (b) The commissioner of health shall provide the commissioner of human services with
511.11 the required data to complete the report in paragraph (a) and implement the moratorium on
511.12 home and community-based services customized living settings under Minnesota Statutes,
511.13 section 256B.49, subdivision 28. The data must include, at a minimum, each registered
511.14 housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as
511.15 a customized living setting to deliver customized living services as defined under the brain
511.16 injury or community access for disability inclusion waiver plans under Minnesota Statutes,
511.17 section 256B.49.

583.8 256S.20, subdivision 1, paragraph (a), clause (2), in consultation with stakeholders. The
583.9 commissioner may provide recommendations to the chairs and ranking minority members
583.10 of the legislative committees and divisions with jurisdiction over customized living services
583.11 by February 15, 2022, regarding appropriate regulatory oversight and payment policies for
583.12 customized living services delivered in these settings.

583.13 Sec. 41. **GOVERNOR'S COUNCIL ON AN AGE-FRIENDLY MINNESOTA.**

583.14 The Governor's Council on an Age-Friendly Minnesota, established in Executive Order
583.15 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and
583.16 private partners' collaborative work on emergency preparedness, with a focus on older
583.17 adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic.
583.18 The Governor's Council on an Age-Friendly Minnesota is extended and expires October 1,
583.19 2022.

507.14 Sec. 63. **PARENTING WITH A DISABILITY; PILOT PROJECT.**

507.15 Subdivision 1. **Purpose.** The commissioner of human services shall establish a pilot
507.16 project to provide grants to personal care assistance provider agencies to provide assistance
507.17 with child rearing tasks to a parent who is eligible for personal care assistance services
507.18 under Minnesota Statutes, section 256B.0659, or for services and supports provided through
507.19 community first services and supports under Minnesota Statutes, section 256B.85. The
507.20 purpose of this pilot project is to study the benefits of supportive parenting while assisting
507.21 parents with a disability in child rearing tasks and preventing removal of a child from a
507.22 parent because the parent has a disability.

507.23 Subd. 2. **Definitions.** (a) For the purposes of this section, in addition to the definitions
507.24 in Minnesota Statutes, section 256B.0659, subdivision 1, applying to the personal care
507.25 assistance program and the definitions in Minnesota Statutes, section 256B.85, subdivision
507.26 2, applying to community first services and supports, the following terms have the meanings
507.27 given them in this subdivision.

507.28 (b) "Adaptive parenting equipment" means a piece of equipment that increases, extends,
507.29 or improves the parenting capabilities of a parent with a disability.

507.30 (c) "Child" means a person under 12 years of age.

507.31 (d) "Child rearing task" means a task that assists a parent with a disability to care for a
507.32 child. Child rearing task includes, but is not limited to: lifting and carrying a child, organizing
507.33 supplies for a child, preparing meals for a child, washing clothing and bedding for a child,
508.1 bathing a child, childproofing the home that the parent and child live in, and assisting with
508.2 transporting a child.

508.3 (e) "Commissioner" means the commissioner of human services.

508.4 (f) "Parent" means a child's biological, foster, or adoptive parent or legal guardian who
508.5 is legally obligated to care for and support the child.

508.6 (g) "Person with a disability" means an individual who has a physical, mental, or
508.7 psychological impairment or dysfunction that limits independent functioning in a family,
508.8 community, or employment.

508.9 (h) "Personal care assistant" or "PCA" also means support worker.

508.10 (i) "Personal care assistance services" also means the services and supports provided by
508.11 community first services and supports.

508.12 (j) "Supportive parenting assistant" or "SPA" means an individual providing supportive
508.13 parenting services who is also a personal care assistant.

508.14 (k) "Supportive parenting service" means a state-funded service that (1) helps a parent
508.15 with a disability compensate for aspects of the parent's disability that affect the parent's
508.16 ability to care for the child, and (2) enables the parent to complete parental responsibilities,
508.17 including child rearing tasks. Supportive parenting service does not include disciplining the
508.18 parent's child.

508.19 Subd. 3. **Grants.** (a) The commissioner shall develop a competitive application process
508.20 for up to three two-year state-funded grants to personal care assistance provider agencies
508.21 to provide supportive parenting services described in subdivision 4 and to purchase adaptive
508.22 parenting equipment described in subdivision 5. A grant applicant must be a personal care
508.23 assistance provider agency.

508.24 (b) Grant applications must describe how the applicant would recruit families to
508.25 participate in the pilot project and how the applicant would select families to receive
508.26 supportive parenting services while giving preference to families in which both parents are
508.27 receiving personal care assistance services.

508.28 (c) Grantees must agree to provide supportive parenting to each selected family for at
508.29 least one year.

508.30 Subd. 4. **Supportive parenting services.** (a) If a parent is eligible for and receiving
508.31 personal care assistance services, the parent is eligible to receive supportive parenting
508.32 services funded by a grant under this section. A parent must use one supportive parenting
509.1 assistant at a time, regardless of the parent's number of children. Supportive parenting
509.2 services provided under this section are services for the parent and not the child.

509.3 (b) An SPA providing supportive parenting services under this section must not perform
509.4 personal care assistance services while scheduled to provide supportive parenting services.
509.5 A PCA providing personal care assistance services must not perform supportive parenting
509.6 services while scheduled to provide personal care assistance services. A PCA providing
509.7 personal care assistance services and an SPA providing supportive parenting services may
509.8 be scheduled to support the parent at the same time. The same individual may provide
509.9 personal care assistance services and supportive parenting assistance to a parent as long as

509.10 the requirements of this paragraph are met. Supportive parenting services under this section
509.11 do not count toward a PCA's 310 hours per-month limit on providing personal care assistance
509.12 services under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (a), clause
509.13 (10).

509.14 (c) Supportive parenting services under this section must not replace personal care
509.15 assistance services.

509.16 (d) A parent's supportive parenting services shall be limited to 40 hours per month.

509.17 Subd. 5. **Adaptive parenting equipment.** A grantee may purchase adaptive parenting
509.18 equipment at the request of a parent receiving supportive parenting services under subdivision
509.19 4. A grantee must not purchase adaptive parenting equipment covered by medical assistance.
509.20 A grantee must purchase the least costly item to meet the parent's need.

509.21 Sec. 64. **DIRECTION TO THE COMMISSIONER; STUDY OF SUPPORTIVE**
509.22 **PARENTING SERVICES.**

509.23 The commissioner shall study the feasibility of providing supportive parenting services
509.24 to parents with disabilities and disabling conditions as a covered medical assistance service
509.25 and submit a report to the chairs and ranking minority members of the legislative committees
509.26 with jurisdiction over health and human services by February 15, 2023. The report must
509.27 contain at a minimum:

509.28 (1) the total number of parents that were provided services through the pilot project;

509.29 (2) the total cost of developing and providing the services provided under the pilot
509.30 project;

509.31 (3) recommendations on expansion or continuation of the pilot project;

510.1 (4) recommendations on seeking federal approval of supportive parenting services as a
510.2 covered service under medical assistance; and

510.3 (5) draft legislative language.

510.4 Sec. 65. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PLAN**
510.5 **FOR ADDRESSING EFFECTS ON COMMUNITY OF CERTAIN**
510.6 **STATE-OPERATED SERVICES.**

510.7 The commissioner of human services, in consultation with stakeholders, shall develop
510.8 and submit to the chairs and ranking minority members of the house of representatives and
510.9 senate committees with jurisdiction over health and human services by January 31, 2022,
510.10 a plan to ameliorate the effects of repeated incidents, as defined in Minnesota Statutes,
510.11 section 245D.02, subdivision 11, occurring at Minnesota state-operated community services
510.12 programs that affect the community in which the program is located and the neighbors of
510.13 the service site of the program.

510.14 Sec. 66. **DIRECTION TO THE COMMISSIONER; INITIAL PACE**
510.15 **IMPLEMENTATION FUNDING.**

510.16 The commissioner of human services must work with stakeholders to develop
510.17 recommendations for financing mechanisms to complete the actuarial work and cover the
510.18 administrative costs of a program of all-inclusive care for the elderly (PACE). The
510.19 commissioner must recommend a financing mechanism that could begin July 1, 2023. The
510.20 commissioner shall inform the chairs and ranking minority members of the legislative
510.21 committees with jurisdiction over health care funding by December 15, 2022, on the
510.22 commissioner's progress toward developing a recommended financing mechanism.

511.18 Sec. 68. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
511.19 **DIRECT CARE SERVICES DURING SHORT-TERM ACUTE HOSPITAL VISITS.**

511.20 The commissioner of human services, in consultation with stakeholders, shall develop
511.21 a new covered service under Minnesota Statutes, chapter 256B, or develop modifications
511.22 to existing covered services, that permits receipt of direct care services in an acute care
511.23 hospital in a manner consistent with the requirements of United States Code, title 42, section
511.24 1396a(h). By August 31, 2022, the commissioner must provide to the chairs and ranking
511.25 minority members of the house of representatives and senate committees and divisions with
511.26 jurisdiction over direct care services any draft legislation as may be necessary to implement
511.27 the new or modified covered service.

511.28 Sec. 69. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
511.29 **DRIVING AS COVERED SERVICE UNDER COMMUNITY FIRST SERVICES**
511.30 **AND SUPPORTS.**

511.31 The commissioner of human services, in consultation with stakeholders and within
511.32 existing appropriations, shall develop a new covered service under Minnesota Statutes,
511.33 section 256B.85, that permits a support worker to bill as community first services and
512.1 supports, not merely assisting a participant with traveling around and participating in the
512.2 community, or merely accompanying a participant while traveling around or participating
512.3 in the community, but driving the participant to activities in the community, including to
512.4 medical appointments. In developing the new covered services, the commissioner must
512.5 account for any substitution effect that will result from the new covered service supplanting
512.6 nonemergency medical transportation. By December 31, 2021, the commissioner must
512.7 provide to the chairs and ranking minority members of the house of representatives and
512.8 senate committees and divisions with jurisdiction over community first services and supports
512.9 any draft legislation as may be necessary to implement the new covered service.

512.10 Sec. 70. **DIRECTION TO THE COMMISSIONER; LONG-TERM CARE**
512.11 **CONSULTATION SERVICE RATES.**

512.12 By January 15, 2025, the commissioner of human services shall develop a proposal with
512.13 legislative language for capitated rates for each type of assessment or activity provided
512.14 under Minnesota Statutes, section 256B.0911, as determined by the commissioner. The

583.20 Sec. 42. **PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES**
583.21 **PROVIDED BY A PARENT OR SPOUSE.**

583.22 (a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph
583.23 (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), a parent, stepparent, or
583.24 legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal
583.25 care assistance recipient may provide and be paid for providing personal care assistance
583.26 services.

583.27 (b) This section expires upon full implementation and phase-in of the community first
583.28 services and supports program under Minnesota Statutes, section 256B.85.

583.29 **EFFECTIVE DATE.** This section is effective the day following final enactment or
583.30 upon federal approval. The commissioner of human services shall notify the revisor of
583.31 statutes when federal approval is obtained.

584.1 Sec. 43. **RATE INCREASE FOR DIRECT SUPPORT SERVICES WORKFORCE.**

584.2 (a) Effective October 1, 2021, or upon federal approval, whichever is later, if the labor
584.3 agreement between the state of Minnesota and the Service Employees International Union
584.4 Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to
584.5 Minnesota Statutes, section 3.855, the commissioner of human services shall increase:

584.6 (1) reimbursement rates, individual budgets, grants, or allocations by 4.14 percent for
584.7 services under paragraph (b) provided on or after October 1, 2021, or upon federal approval,
584.8 whichever is later, to implement the minimum hourly wage, holiday, and paid time off
584.9 provisions of that agreement;

584.10 (2) reimbursement rates, individual budgets, grants, or allocations by 2.95 percent for
584.11 services under paragraph (b) provided on or after July 1, 2022, or upon federal approval,
584.12 whichever is later, to implement the minimum hourly wage, holiday, and paid time off
584.13 provisions of that agreement;

584.14 (3) individual budgets, grants, or allocations by 1.58 percent for services under paragraph
584.15 (c) provided on or after October 1, 2021, or upon federal approval, whichever is later, to

512.15 commissioner shall provide the proposal and legislative language to the chairs and ranking
512.16 minority members of the legislative committees and divisions with jurisdiction over human
512.17 services policy and finance by January 15, 2025.

512.18 Sec. 71. **HOUSING SUPPORT SUPPLEMENTAL SERVICE RATE REDUCTION**
512.19 **DELAY.**

512.20 The rate reduction described in Minnesota Statutes, section 256B.051, subdivision 7,
512.21 does not apply until October 1, 2021, for individuals who receive supplemental services
512.22 from providers that made a good faith effort to become a Medicaid provider by submitting
512.23 an application by June 1, 2021.

512.24 Sec. 72. **PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES**
512.25 **PROVIDED BY A PARENT OR SPOUSE.**

512.26 (a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph
512.27 (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), a parent, stepparent, or
512.28 legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal
512.29 care assistance recipient may provide and be paid for providing personal care assistance
512.30 services.

512.31 (b) This section expires upon full implementation and phase-in of the community first
512.32 services and supports program under Minnesota Statutes, section 256B.85.

513.1 **EFFECTIVE DATE.** This section is effective the day following final enactment, or
513.2 upon federal approval, whichever is later. The commissioner of human services shall notify
513.3 the revisor of statutes when federal approval is obtained.

584.16 implement the minimum hourly wage, holiday, and paid time off provisions of that
584.17 agreement; and

584.18 (4) individual budgets, grants, or allocations by .81 percent for services under paragraph
584.19 (c) provided on or after July 1, 2022, or upon federal approval, whichever is later, to
584.20 implement the minimum hourly wage, holiday, and paid time off provisions of that
584.21 agreement.

584.22 (b) The rate changes described in paragraph (a), clauses (1) and (2), apply to direct
584.23 support services provided through a covered program, as defined in Minnesota Statutes,
584.24 section 256B.0711, subdivision 1, with the exception of consumer-directed community
584.25 supports available under programs established pursuant to home and community-based
584.26 service waivers authorized under section 1915(c) of the federal Social Security Act and
584.27 Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and
584.28 256B.49, and under the alternative care program under Minnesota Statutes, section
584.29 256B.0913.

584.30 (c) The funding changes described in paragraph (a), clauses (3) and (4), apply to
584.31 consumer-directed community supports available under programs established pursuant to
584.32 home and community-based service waivers authorized under section 1915(c) of the federal
584.33 Social Security Act, and Minnesota Statutes, including but not limited to chapter 256S and
585.1 sections 256B.092 and 256B.49, and under the alternative care program under Minnesota
585.2 Statutes, section 256B.0913.

585.3 Sec. 44. **WAIVER REIMAGINE PHASE II.**

585.4 (a) The commissioner of human services must implement a two-home and
585.5 community-based services waiver program structure, as authorized under section 1915(c)
585.6 of the federal Social Security Act, that serves persons who are determined by a certified
585.7 assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral
585.8 hospital, or an intermediate care facility for persons with developmental disabilities.

585.9 (b) The commissioner of human services must implement an individualized budget
585.10 methodology, as authorized under section 1915(c) of the federal Social Security Act, that
585.11 serves persons who are determined by a certified assessor to require the levels of care
585.12 provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care
585.13 facility for persons with developmental disabilities.

585.14 (c) The commissioner of human services may seek all federal authority necessary to
585.15 implement this section.

585.16 **EFFECTIVE DATE.** This section is effective September 1, 2024, or 90 days after
585.17 federal approval, whichever is later. The commissioner of human services shall notify the
585.18 revisor of statutes when federal approval is obtained.

513.4 Sec. 73. **DIRECTIONS TO THE COMMISSIONER OF HUMAN SERVICES;**
513.5 **WAIVER GROWTH LIMITS.**

513.6 Subdivision 1. **Community access for disability inclusion waiver growth**
513.7 **limit.** Between July 1, 2021, and June 30, 2025, the commissioner shall allocate to county
513.8 and Tribal agencies money for home and community-based waiver programs under Minnesota
513.9 Statutes, section 256B.49, to ensure a reduction in forecasted state spending that is equivalent
513.10 to limiting the caseload growth of the community access for disability inclusion waiver to
513.11 zero allocations per year. Limits do not apply to conversions from nursing facilities. Counties
513.12 and Tribal agencies shall manage the annual allocations made by the commissioner to ensure
513.13 that persons for whom services are temporarily discontinued for no more than 90 days are
513.14 reenrolled. If a county or Tribal agency fails to meet the authorization and spending
513.15 requirements under Minnesota Statutes, section 256B.49, subdivision 27, the commissioner
513.16 may determine a corrective action plan is unnecessary if the failure to meet the requirements
513.17 is due to managing the annual allocation for the purposes of allowing people to reenroll
513.18 after their services are temporarily discontinued.

513.19 Subd. 2. **Developmental disabilities waiver growth limit.** Between July 1, 2021, and
513.20 June 30, 2025, the commissioner shall allocate to county and Tribal agencies money for
513.21 home and community-based waiver programs under Minnesota Statutes, section 256B.092,
513.22 to ensure a reduction in forecasted state spending that is equivalent to limiting the caseload
513.23 growth of the developmental disabilities waiver to zero allocations per year. Limits do not
513.24 apply to conversions from intermediate care facilities for persons with developmental
513.25 disabilities. Counties and Tribal agencies shall manage the annual allocations made by the
513.26 commissioner to ensure that persons for whom services are temporarily discontinued for
513.27 no more than 90 days are reenrolled.

513.28 Sec. 74. **RETAINER PAYMENTS FOR HOME AND COMMUNITY-BASED**
513.29 **SERVICE PROVIDERS.**

513.30 Subdivision 1. **Retainer payments.** (a) The commissioner of human services shall make
513.31 quarterly retainer payments to eligible recipients by July 1, 2021; September 30, 2021;
513.32 December 31, 2021; March 31, 2022; and June 30, 2022. The value of the first quarterly
513.33 payment to each eligible recipient shall be equal to a percentage to be determined by the
514.1 commissioner under subdivision 9 applied to the eligible recipient's total home and
514.2 community-based service revenue from medical assistance as of May 31, 2021. The value
514.3 of each subsequent quarterly payment shall be equal to a percentage to be determined by
514.4 the commissioner under subdivision 9 applied to the eligible recipient's total home and
514.5 community-based service revenue from medical assistance based on new data for service
514.6 claims paid as of the first day of the month in which the retainer payment will be made.

514.7 (b) The commissioner shall implement retainer payments and the process of making
514.8 retainer payments under this subdivision without compliance with time-consuming procedures
514.9 and formalities prescribed in law, such as the following statutes and related policies:

- 514.10 Minnesota Statutes, sections 16A.15, subdivision 3; 16B.97; 16B.98, subdivisions 5 and 7;
514.11 and 16B.98, subdivision 8, the express audit clause requirement.
- 514.12 (c) The commissioner's determination of the retainer amount determined under this
514.13 subdivision is final and is not subject to appeal. This paragraph does not apply to recoupment
514.14 by the commissioner under subdivision 8.
- 514.15 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
514.16 given:
- 514.17 (1) "direct care professional" means any individual who while providing an eligible
514.18 service has direct contact with the person receiving the eligible service. Direct care
514.19 professional excludes executive, managerial, and administrative staff;
- 514.20 (2) "eligible recipient" means an enrolled provider of eligible services, including the
514.21 Direct Care and Treatment Division at the Department of Human Services, that meets the
514.22 attestation and agreement requirements in subdivisions 5 and 6;
- 514.23 (3) "eligible service" means a home and community-based service as defined in section
514.24 9817(a)(2)(B) of the federal American Rescue Plan Act, Public Law 117-2, except:
- 514.25 (i) community first services and supports;
- 514.26 (ii) extended community first services and supports;
- 514.27 (iii) personal care assistance services;
- 514.28 (iv) extended personal care assistance service;
- 514.29 (v) consumer-directed community supports;
- 514.30 (vi) consumer support grants;
- 514.31 (vii) home health agency services; and
- 515.1 (viii) home care nursing services;
- 515.2 (4) "recipient" means an enrolled provider of an eligible service that receives a retainer
515.3 payment under this section; and
- 515.4 (5) "total home and community-based service revenue from medical assistance" includes
515.5 both fee-for-service revenue and revenue from managed care organizations attributable to
515.6 the provision of eligible services from April 1, 2021, to March 31, 2022. The commissioner
515.7 shall determine each eligible provider's total home and community-based service revenue
515.8 from medical assistance based on data for service claims paid as of the date specified in
515.9 subdivision 9.

515.10 Subd. 3. **Allowable uses of funds.** (a) Recipients must use retainer payments to
515.11 implement one or more of the following activities to enhance, expand, or strengthen home
515.12 and community-based services:

515.13 (1) temporarily increase wages, salaries, and benefits for direct care professionals and
515.14 any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state
515.15 and federal unemployment taxes, and workers' compensation premiums;

515.16 (2) provide hazard pay, overtime pay, and shift differential pay for direct care
515.17 professionals;

515.18 (3) pay for paid sick leave, paid family leave, and paid medical leave due to COVID-19
515.19 for direct care professionals;

515.20 (4) pay for training for direct care professionals that is specific to the COVID-19 public
515.21 health emergency;

515.22 (5) recruit new direct care professionals;

515.23 (6) pay for American sign language and other languages interpreters to assist in providing
515.24 eligible services or to inform the general public about COVID-19;

515.25 (7) purchase emergency supplies and equipment to enhance access to eligible services
515.26 and to protect the health and well-being of direct care professionals;

515.27 (8) support family care providers of eligible individuals with needed supplies and
515.28 equipment, which may include items not typically covered under the Medicaid program,
515.29 such as personal protective equipment and pay; and

515.30 (9) pay for assistive technologies, staffing, and other costs incurred during the COVID-19
515.31 public health emergency period to mitigate isolation and ensure an individual's
515.32 person-centered service plan continues to be fully implemented.

516.1 (b) Recipients must:

516.2 (1) use at least 50 percent of the additional revenue received in the form of retainer
516.3 payments for the purposes described in paragraph (a), clauses (1) to (3); and

516.4 (2) use any remainder of the additional revenue received in the form of retainer payments
516.5 for the purposes described in paragraph (a), clauses (4) to (9).

516.6 Subd. 4. **Retainer payment requests.** Eligible recipients must request retainer payments
516.7 under this section no later than June 1, 2022. The commissioner shall develop an expedited
516.8 request process that includes a form allowing providers to meet the requirements of
516.9 subdivisions 5 and 6 in as timely a manner as possible. The commissioner shall allow the
516.10 use of electronic submission of request forms and accept electronic signatures.

- 516.11 Subd. 5. **Attestation.** (a) As a condition of obtaining funds under this section, an eligible
516.12 recipient must attest to the following on the retainer payment request form:
- 516.13 (1) the intent to provide eligible services through March 31, 2022; and
516.14 (2) that the recipient will use the retainer payments only for purposes permitted under
516.15 this section.
- 516.16 (b) By accepting a retainer payment under this section, the recipient attests to the
516.17 conditions specified in this subdivision.
- 516.18 Subd. 6. **Agreement.** (a) As a condition of receiving retainer payments under this section,
516.19 an eligible recipient must agree to the following on the retainer payment request form:
- 516.20 (1) to cooperate with the commissioner of human services to deliver services according
516.21 to the program and service waivers and modifications issued under the commissioner's
516.22 authority;
- 516.23 (2) to acknowledge that retention grants may be subject to a special recoupment under
516.24 this section if a state audit performed under this section determines that the provider used
516.25 retainer payments for purposes not authorized under this section; and
- 516.26 (3) to acknowledge that a recipient must comply with the distribution requirements
516.27 described in subdivision 7.
- 516.28 (b) By accepting a retainer payment under this section, the recipient agrees to the
516.29 conditions specified in this subdivision.
- 516.30 Subd. 7. **Distribution plans.** (a) A recipient must prepare and, upon request, submit to
516.31 the commissioner, a distribution plan that specifies the anticipated amount and proposed
516.32 uses of the additional revenue the recipient will receive under this section.
- 517.1 (b) Within 60 days of receipt of the recipient's first retainer payment, the recipient must
517.2 post the distribution plan and leave it posted for a period of at least six weeks in an area of
517.3 the recipient's operation to which all direct care professionals have access. The provider
517.4 must post with the distribution plan instructions on how to contact the commissioner of
517.5 human services if direct care professionals do not believe they have received the wage
517.6 increase or benefits required under subdivision 3 specified in the distribution plan. The
517.7 instructions must include a mailing address, e-mail address, and telephone number that the
517.8 direct care professional may use to contact the commissioner or the commissioner's
517.9 representative.
- 517.10 Subd. 8. **Recoupment.** (a) The commissioner may perform an audit under this section
517.11 up to six years after any retainer payment is made to ensure the funds are utilized solely for
517.12 the purposes authorized under this section.
- 517.13 (b) If the commissioner determines that a provider used retainer payments for purposes
517.14 not authorized under this section, the commissioner shall treat any amount used for a purpose

517.15 not authorized under this section as an overpayment. The commissioner shall recover any
517.16 overpayment.

517.17 Subd. 9. **Calculation of retainer payments.** (a) The commissioner shall determine a
517.18 percentage to apply to each recipient's total home and community-based service revenue
517.19 from medical assistance to calculate the value of each quarterly retainer payment.

517.20 (b) The commissioner shall make an estimate of the total projected expenditures for
517.21 eligible services between April 1, 2021, and March 31, 2022, determine a percentage to be
517.22 applied to the total projected home and community-based service revenue from medical
517.23 assistance for all providers of eligible services sufficient to expend the total appropriation
517.24 for retainer payments, and apply this percentage to each recipient's total home and
517.25 community-based service revenue from medical assistance on the following schedule:

517.26 (1) no earlier than July 1, 2021, make a retainer payment by applying the percentage to
517.27 each recipient's total home and community-based service revenue from medical assistance
517.28 based on service claims paid as of May 31, 2021;

517.29 (2) no later than September 30, 2021, make a retainer payment by applying the percentage
517.30 to each recipient's total home and community-based service revenue from medical assistance
517.31 based on new service claims paid as of September 1, 2021, that were not included in the
517.32 calculation of a prior retainer payment;

517.33 (3) no later than December 31, 2021, make a retainer payment by applying the percentage
517.34 to each recipient's total home and community-based service revenue from medical assistance
518.1 based on new service claims paid as of December 1, 2021, that were not included in the
518.2 calculation of a prior retainer payment; and

518.3 (4) no later than March 31, 2022, make a retainer payment by applying the percentage
518.4 to each recipient's total home and community-based service revenue from medical assistance
518.5 based on new service claims paid as of March 1, 2022, that were not included in the
518.6 calculation of a prior retainer payment.

518.7 (c) The commissioner may redetermine the percentage to be applied to each recipient's
518.8 total home and community-based services revenue from medical assistance.

518.9 (d) By June 30, 2022, the commissioner shall redetermine a percentage to be applied to
518.10 the total home and community-based service revenue from medical assistance based on
518.11 new service claims paid as of June 1, 2021, that were not included in the calculation of a
518.12 prior retainer payment. The redetermined percentage must be sufficient to expend the total
518.13 appropriation for retainer payments. No later than June 30, 2022, the commissioner shall
518.14 make a final retainer payment by applying the redetermined percentage to each recipient's
518.15 total home and community-based service revenue from medical assistance based on new
518.16 service claims paid as of June 1, 2021, that were not included in the calculation of a prior
518.17 retainer payment.

518.18 Sec. 75. **DIRECTION TO THE COMMISSIONER; PERSONAL CARE**
518.19 **ASSISTANCE SERVICE RATE INCREASES.**

518.20 Effective July 1, 2021, The commissioner of human services shall increase the
518.21 reimbursement rates, individual budgets, grants, and allocations for community first services
518.22 and supports under Minnesota Statutes, section 256B.85; personal care assistance services
518.23 under Minnesota Statutes, section 256B.0659; extended personal care assistance service as
518.24 defined in Minnesota Statutes, section 256B.0605, subdivision 1, paragraph (g); and extended
518.25 community first services and supports as defined in Minnesota Statutes, section 256B.85,
518.26 subdivision 2, paragraph (l); and for budgets of individuals utilizing consumer-directed
518.27 community supports or participating in the consumer support grant program. The
518.28 commissioner shall determine the amount of the rate increase to ensure that the state share
518.29 of the increase does not exceed the amount appropriated in each fiscal year for this purpose
518.30 in this act.

518.31 **EFFECTIVE DATE.** This section is effective July 1, 2021.

519.1 Sec. 76. **DIRECTION TO THE COMMISSIONER; HOME CARE SERVICE RATE**
519.2 **INCREASE.**

519.3 Effective July 1, 2021, The commissioner of human services shall increase service rates
519.4 for home health agency services under Minnesota Statutes, section 256B.0653, and for home
519.5 care nursing services under Minnesota Statutes, section 256B.0654. The commissioner shall
519.6 determine the amount of the rate increase to ensure that the state share of the increase does
519.7 not exceed the amount appropriated in this act in each fiscal year for this purpose.

519.8 **EFFECTIVE DATE.** This section is effective July 1, 2021.

519.9 Sec. 77. **DIRECTION TO THE COMMISSIONER; ELDERLY WAIVER RATE**
519.10 **INCREASE.**

519.11 The commissioner of human services shall modify the ratio of the blended rate described
519.12 under Minnesota Statutes, section 256S.2101, to increase statewide service rates and
519.13 component service rates. The commissioner shall also adjust service rate limits, monthly
519.14 service rate limits, and monthly case mix budget caps to accommodate the increased service
519.15 rates and component service rates established under this section. The commissioner shall
519.16 modify the blended rates to ensure that the state share of the service rate increase does not
519.17 exceed the amount appropriated in each fiscal year for this purpose in this act.

519.18 Sec. 78. **REVISOR INSTRUCTION.**

519.19 (a) The revisor of statutes, in consultation with the Office of Senate Counsel, Research
519.20 and Fiscal Analysis, the Office of the House Research Department, and the commissioner
519.21 of human services, shall prepare legislation for the 2022 legislative session to recodify
519.22 Minnesota Statutes, sections 256.975, subdivisions 7 to 7d, and 256B.0911.

519.23 (b) The revisor of statutes, in consultation with the Office of Senate Counsel, Research
519.24 and Fiscal Analysis, the Office of the House Research Department, and the commissioner

585.19 Sec. 45. **REPEALER.**

- 585.20 (a) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are
585.21 repealed effective July 1, 2021.
- 585.22 (b) Minnesota Statutes 2020, sections 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, and 12;
585.23 and 256B.49, subdivisions 26 and 27, are repealed effective January 1, 2023, or upon federal
585.24 approval, whichever is later. The commissioner of human services shall notify the revisor
585.25 of statutes when federal approval is obtained.
- 585.26 (c) Minnesota Statutes 2020, section 256S.20, subdivision 2, is repealed effective August
585.27 1, 2021.

- 519.25 of human services, shall to the greatest extent practicable renumber as subdivisions the
519.26 paragraphs of Minnesota Statutes, section 256B.4914, prior to the publication of the 2021
519.27 Supplement of Minnesota Statutes, and shall without changing the meaning or effect of
519.28 these provisions minimize the use of internal cross-references, including by drafting new
519.29 technical definitions as substitutes for necessary cross-references or by other means
519.30 acceptable to the commissioner of human services.
- 520.1 (c) The revisor of statutes shall change the headnote for Minnesota Statutes, section
520.2 256B.097, to read "REGIONAL AND SYSTEMS IMPROVEMENT FOR MINNESOTANS
520.3 WHO HAVE DISABILITIES."
- 520.4 Sec. 79. **REPEALER.**
- 520.5 (a) Minnesota Statutes 2020, section 256B.4905, subdivisions 1, 2, 3, 4, 5, and 6, are
520.6 repealed.
- 520.7 (b) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are
520.8 repealed.
- 520.9 (c) Laws 2019, First Special Session chapter 9, article 5, section 90, is repealed.