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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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 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) a description of the proposed project;

(4) an analysis of projected costs of the nursing facility proposed project, including:

(i) initial construction and remodeling costs;

(ii) site preparation costs;

(iii) equipment and technology costs;

(iv) financing costs, the current estimated long-term financing costs of the proposal, which is to include details of any proposed funding mechanism already arranged or being considered, including estimates of the amount and sources of money, reserves if required, annual payments schedule, interest rates, length of term, closing costs and fees, insurance costs, any completed marketing study or underwriting review; and

(v) estimated operating costs during the first two years after completion of the project;

(5) for proposals involving replacement of all or part of a facility, the proposed location of the replacement facility and an estimate of the cost of addressing the problem through renovation;

(6) for proposals involving renovation, an estimate of the cost of addressing the problem through replacement;

(7) the proposed timetable for commencing construction and completing the project;

(8) a statement of any licensure or certification issues, such as certification survey deficiencies;

(9) the proposed relocation plan for current residents if beds are to be closed according to section 144A.161; and

(10) other information required by permanent rule of the commissioner of health in accordance with subdivisions 4 and 8.

Sec. 3. Minnesota Statutes 2020, section 144A.073, is amended by adding a subdivision to read:

Subd. 17. **Moratorium exception funding.** (a) During the biennium beginning July 1, 2021, and during each biennium thereafter, the commissioner of health may approve moratorium exception projects under this section for which the full biennial state share of medical assistance costs does not exceed $10,000,000, plus any carryover of previous appropriations for this purpose.

(b) For the purposes of this subdivision, "biennium" has the meaning given in section 16A.011, subdivision 6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

256.477 SELF-ADVOCACY GRANTS.

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

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

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

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

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

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

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

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

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

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

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

(1) housing;

(2) employment;

(3) education;

(4) transportation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) providing public education and awareness of the civil and human rights of persons with intellectual and developmental disabilities.

Subd. 5. **Reports.** (a) Grant recipients shall provide the advisory committee with a report about the activities funded by the grant program in a format and at a time specified by the advisory committee. The advisory committee shall require grant recipients to include in the grant recipient's report at least the information necessary for the advisory committee to meet the advisory committee's obligation under paragraph (b).

(b) The advisory committee shall provide the commissioner with a report that describes all of the activities and outcomes of projects funded by the grant program in a format and at a time determined by the commissioner.

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

(a) The commissioner shall make a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of children with any type of disability or special health care needs. An eligible alliance member must have an established parent-to-parent peer support program that is statewide and represents diverse cultures and geographic locations, that conducts outreach and provides individualized support to any parent or guardian of a child with a disability or special health care need, including newly identified parents of such a child or parents experiencing transitions or changes in their child's care, and that implements best practices for peer-to-peer support, including providing support from trained parent staff and volunteer support parents who have received Parent to Parent USA's specialized parent-to-parent peer support training.

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

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

(d) Grant recipients must report to the commissioner of human services annually by January 15 about the services and programs funded by this grant. The report must include measurable outcomes from the previous year, including the number of families served by the organization's parent-to-parent programs and the number of volunteer support parents trained by the organization's parent-to-parent programs.

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

Subdivision 1. **Long-term care facility.** "Long-term care facility" means a nursing home licensed under sections 144A.02 to 144A.10; a boarding care home licensed under sections 144.50 to 144.56; an assisted living facility or an assisted living facility with dementia care licensed under chapter 144G; ~~or~~ a licensed or registered residential setting that provides or arranges for the provision of home care services; or a setting defined under section 144G.08,

subdivision 7, clauses (10) to (13), that provides or arranges for the provision of home care services.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 8. Minnesota Statutes 2020, section 256B.0653, is amended by adding a subdivision to read:

Subd. 8. **Payment rates for home health agency services.** The commissioner shall annually adjust payments for home health agency services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later, for services delivered on or after January 1, 2022. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2020, section 256B.0654, is amended by adding a subdivision to read:

Subd. 5. **Payment rates for home care nursing services.** The commissioner shall annually adjust payments for home care nursing services to reflect the change in the federal Centers for Medicare and Medicaid Services Home Health Agency Market Basket. The commissioner shall use the indices as forecasted for the midpoint of the prior rate year to the midpoint of the current rate year.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later, for services delivered on or after January 1, 2022. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) any other manner prescribed by the commissioner.

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

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

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

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

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

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

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

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

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

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

(1) service eligibility determination for the following state plan services:

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

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

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

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

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

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

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(g) "Informed choice" ~~means a voluntary choice of services, settings, living arrangement, and work by a person from all available service and setting options based on accurate and complete information concerning all available service and setting options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person in a way the person can understand to empower the person to make fully informed choices~~ has the meaning given in section 256B.4905, subdivision 1a, paragraph (b).

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

(i) "Independent living" means living in a setting that is not controlled by a provider.

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

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

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

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

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

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

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

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

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

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

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

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

(g) The written community support plan must include:

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

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

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

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

(iii) all available options for living arrangements;

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

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

(g) The written community support plan must include:

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

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

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

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

(iii) all available options for living arrangements;

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

(3) between day services and employment services; and

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

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

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

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

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

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

(5) information about Minnesota health care programs;

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

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

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

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

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

(3) between day services and employment services; and

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

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

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

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

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

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

(5) information about Minnesota health care programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) This subdivision expires July 1, 2025.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) meet other priorities established by the department.

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

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

Subd. 7. **Regional quality councils and systems improvement.** The commissioner of human services shall maintain the regional quality councils initially established under Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils shall:

(1) support efforts and initiatives that drive overall systems and social change to promote inclusion of people who have disabilities in the state of Minnesota;

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

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

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

Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of key stakeholders including, but not limited to:

(1) individuals who have disabilities;

(2) family members of people who have disabilities;

(3) disability service providers;

(4) disability advocacy groups;

(5) lead agency staff; and

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

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

Subd. 7. **Regional quality councils and systems improvement.** The commissioner of human services shall maintain the regional quality councils initially established under Minnesota Statutes 2020, section 256B.097, subdivision 4. The regional quality councils shall:

(1) support efforts and initiatives that drive overall systems and social change to promote inclusion of people who have disabilities in the state of Minnesota;

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

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

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

Subd. 8. **Membership and staff.** (a) Regional quality councils shall be comprised of key stakeholders including, but not limited to:

(1) individuals who have disabilities;

(2) family members of people who have disabilities;

(3) disability service providers;

(4) disability advocacy groups;

(5) lead agency staff; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

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

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

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

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

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

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

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

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

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

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

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) meet other priorities established by the department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) leases must comply with chapter 504B;

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

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

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

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

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

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

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

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

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

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

(1) the reason the landlord denied the transfer;

(2) the plan to overcome the denial to transfer the lease;

(3) the length of time needed to successfully transfer the lease, not to exceed an additional two years;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2020, section 256B.4905, is amended by adding a subdivision to read:

Subd. 3a. **Informed decision making.** (a) The commissioner of human services and lead agencies shall ensure that:

(1) disability services support the presumption that adults who have disabilities and, with support from their families or legal representatives, children who have disabilities can make informed choices;

(2) all adults who have disabilities and are accessing HCBS and all families of children who have disabilities and are accessing HCBS are provided an informed decision-making process satisfying the requirements of paragraph (b);

(3) all adults who have disabilities and are accessing HCBS and all families of children who have disabilities and are accessing HCBS are provided the opportunity to revisit or change any decision or choice at any time of the adult's or family's choosing; and

(4) services or supports necessary to accomplish each step of an informed decision-making process or to make an informed choice to utilize disability services are authorized and implemented within a reasonable time frame for individuals accessing HCBS.

(b) The commissioner of human services must develop and ensure compliance with an informed decision-making standard that provides accessible, correct, and complete information to help an individual accessing HCBS make an informed choice. This information must be accessible and understandable to the person so that the person can demonstrate understanding of the options. Any written information provided in the process must be accessible and the process must be experiential whenever possible. The process must also consider and offer to the person, in a person-centered manner, the following:

(1) reasonable accommodations as needed or requested by the person to fully participate in the informed decision-making process and acquire the information necessary to make an informed choice;

(2) discussion of the person's own preferences, abilities, goals, and objectives;

(3) identification of the person's cultural needs and access to culturally responsive services and providers;

(4) information about the benefits of inclusive and individualized services and supports;

(5) presentation and discussion of all options with the person;

(6) documentation, in a manner prescribed by the commissioner, of each option discussed;

(7) exploration and development of new or other options;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) typical education needed for entry;

(2) work experience in a related occupation; and

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

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

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

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

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

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

245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

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

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

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

(l) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(m) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

(n) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

(o) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

(p) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

(c) Component values for family foster care are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 3.3 percent;

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

(7) absence factor: 1.7 percent.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

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

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(d) Component values for day support services and prevocational services delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.67 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(f) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(e) Component values for day support services and prevocational services delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(f) Component values for adult day services are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 7.4 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

~~(f)~~ (g) Component values for unit-based services with programming are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(g) Component values for unit-based services with programming delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan supports ratio: 5.6 percent;

(6) client programming and supports ratio: 1.53 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (h) Component values for unit-based services with programming delivered remotely are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan supports ratio: 15.5 percent;

(6) client programming and supports ratio: 4.7 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 6.1 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

(i) Component values for unit-based services without programming except respite are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 1.3 percent;

(6) client programming and support ratio: 1.14 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

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

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

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

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

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

(9) absence and utilization factor ratio: 3.9 percent.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing shall be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours shall be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

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

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

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

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

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

(d) The payment methodology for customized living and, 24-hour customized living, ~~and residential care~~ services must be the customized living tool. ~~Revisions to~~ The commissioner shall revise the customized living tool ~~must be made~~ to reflect the services and activities unique to disability-related recipient needs , adjust for regional differences in the cost of providing services, and the rate adjustments described in section 256S.205. Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit. The commissioner shall establish acuity-based input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section.

(e) Payments for integrated community support services must be calculated as follows:

(1) the base shared staffing ~~shall~~ must be eight hours divided by the number of people receiving support in the integrated community support setting;

(2) the individual staffing hours ~~shall~~ must be the average number of direct support hours provided directly to the service recipient;

(3) the personnel hourly wage rate must be based on the most recent Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

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

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

(6) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the appropriate staff wages;

(7) multiply the number of shared and individual direct staff hours in clauses (1) and (2) by the product of the supervisory span of control ratio in subdivision 5, paragraph (b), clause (2), and the appropriate supervisory wage in subdivision 5, paragraph (a), clause (21);

(8) combine the results of clauses (6) and (7) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (3). This is defined as the direct staffing cost;

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

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

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

(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(h) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

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

Sec. 24. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day services, day treatment and habilitation, day support services, prevocational services, and structured day services, provided in person or remotely, must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

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

(9) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (4); and

(10) for client programming and supports, the commissioner shall add $2,260.21 divided by 365.

(f) The total rate must be calculated as follows:

(1) add the results of paragraph (e), clauses (9) and (10);

(2) add the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

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

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

~~(g) The payment methodology for customized living and 24-hour customized living services must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.~~

~~(h)~~(g) The number of days authorized for all individuals enrolling in residential services must include every day that services start and end.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, except the fourth sentence of paragraph (d) is effective January 1, 2022. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2020, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day services, day treatment and habilitation, day support services, prevocational services, and structured day services provided in person or remotely must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

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

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

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

(5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (2), for in-person services or subdivision 5, paragraph (d), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (3), for in-person services or subdivision 5, paragraph (d), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (5), for in-person services or subdivision 5, paragraph (d), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (4), for in-person services or subdivision 5, paragraph (d), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(d)~~ (c), clause (6), for in-person services or subdivision 5, paragraph (d), clause (6), for remote services;

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs for in-person service only;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount;

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

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

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

(5) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage;

(6) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (2), for in-person services or subdivision 5, paragraph (e), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (3), for in-person services or subdivision 5, paragraph (e), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (5), for in-person services or subdivision 5, paragraph (e), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (4), for in-person services or subdivision 5, paragraph (e), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (6), for in-person services or subdivision 5, paragraph (e), clause (6), for remote services;

(11) for program facility costs, add ~~$19.30~~ $20.02 per week with consideration of staffing ratios to meet individual needs;

(12) for adult day bath services, add $7.01 per 15 minute unit;

(13) this is the subtotal rate;

(14) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(15) divide the result of clause (13) by one minus the result of clause (14). This is the total payment amount;

(16) adjust the result of clause (15) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

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

Sec. 25. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, and hourly supported living services provided to an individual outside of any day or residential service plan, provided in person or remotely,

(17) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(18) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

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

Sec. 39. Minnesota Statutes 2020, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including employment exploration services, employment development services, housing access coordination, individualized home supports with family training, individualized home supports with training, in-home family support, independent living skills training, and hourly supported living services provided to an individual outside of any day or residential service plan provided in person or remotely

must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

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

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

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

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (2), for in-person services or subdivision 5, paragraph (g), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (3), for in-person services or subdivision 5, paragraph (g), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan supports ratio in subdivision 5, paragraph (f), clause (5), for in-person services or subdivision 5, paragraph (g), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (4), for in-person services or subdivision 5, paragraph (g), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and supports ratio in subdivision 5, paragraph (f), clause (6), for in-person services or subdivision 5, paragraph (g), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

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

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

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

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (2), for in-person services or subdivision 5, paragraph (h), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (3), for in-person services or subdivision 5, paragraph (h), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (5), for in-person services or subdivision 5, paragraph (h), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (4), for in-person services or subdivision 5, paragraph (h), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and supports ratio in subdivision 5, paragraph ~~(f)~~ (g), clause (6), for in-person services or subdivision 5, paragraph (h), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for employment exploration services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed six. For independent living skills training, individualized home supports with training, and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 26. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan, provided in person or remotely, must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

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

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

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

(5) multiply the number of direct staff hours by the appropriate staff wage;

(14) for employment exploration services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed five. For employment support services provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed six. For independent living skills training~~, individualized home supports with training,~~ and individualized home supports with family training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two. For individualized home supports with training, provided in a shared manner, including for a day unit of individualized home supports with training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. (a) Except for the amendment to clause (14), this section is effective January 1, 2022, six months after the end of the federal public health emergency, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when the federal public health emergency ends and when federal approval is obtained.

(b) The amendment to clause (14) is effective January 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 40. Minnesota Statutes 2020, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including individualized home supports, night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan provided in person or remotely must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

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

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

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

(5) multiply the number of direct staff hours by the appropriate staff wage;

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (2), for in-person services or subdivision 5, paragraph (i), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (3), for in-person services or subdivision 5, paragraph (i), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (5), for in-person services or subdivision 5, paragraph (i), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (4), for in-person services or subdivision 5, paragraph (i), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (h), clause (6), for in-person services or subdivision 5, paragraph (i), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for respite services, determine the number of day units of service to meet an individual's needs;

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

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(h)~~ (j), clause (1);

(17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (16);

(18) multiply the number of direct staff hours by the appropriate staff wage;

(19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (2), for in-person services or subdivision 5, paragraph (j), clause (2), for remote services, and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (3), for in-person services or subdivision 5, paragraph (j), clause (3), for remote services. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (5), for in-person services or subdivision 5, paragraph (j), clause (5), for remote services;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (4), for in-person services or subdivision 5, paragraph (j), clause (4), for remote services;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (6), for in-person services or subdivision 5, paragraph (j), clause (6), for remote services;

(11) this is the subtotal rate;

(12) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for respite services, determine the number of day units of service to meet an individual's needs;

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

(16) except for subdivision 5, paragraph (a), clauses (4) and (21) to (23), multiply the result of clause (15) by the product of one plus the competitive workforce factor in subdivision 5, paragraph ~~(h)~~ (k), clause (1);

(17) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (16);

(18) multiply the number of direct staff hours by the appropriate staff wage;

(19) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (2), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(20) combine the results of clauses (18) and (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (3). This is defined as the direct staffing rate;

(21) for employee-related expenses, multiply the result of clause (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (j), clause (4);

(22) this is the subtotal rate;

(23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(24) divide the result of clause (22) by one minus the result of clause (23). This is the total payment amount;

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

(27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 27. Minnesota Statutes 2020, section 256B.4914, is amended by adding a subdivision to read:

Subd. 18. **Payments for family residential services.** The commissioner shall establish rates for family residential services based on a person's assessed needs as described in the federally approved waiver plans.

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

(20) combine the results of clauses (18) and (19), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (3). This is defined as the direct staffing rate;

(21) for employee-related expenses, multiply the result of clause (20) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(h)~~ (k), clause (4);

(22) this is the subtotal rate;

(23) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(24) divide the result of clause (22) by one minus the result of clause (23). This is the total payment amount;

(25) for individualized home supports provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed two;

(26) for respite care services provided in a shared manner, divide the total payment amount in clause (24) by the number of service recipients, not to exceed three; and

(27) adjust the result of clauses (13), (25), and (26) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 41. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision to read:

Subd. 18. **ICF/DD rate increases effective July 1, 2021.** (a) For the rate period beginning July 1, 2021, the commissioner must increase operating payments for each facility reimbursed

under this section equal to five percent of the operating payment rates in effect on June 30, 2021.

(b) For each facility, the commissioner must apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on June 30, 2021. The total rate increase must include the adjustment provided in section 256B.501, subdivision 12.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2020, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **Variable rate adjustments.** (a) ~~For rate years beginning on or after October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1).~~ Once approved, variable rate adjustments must continue to remain in place unless there is an identified change in need. A review of needed resources must be done at the time of the individual's annual support plan meeting. Any change in need identified must result in submission of a request to adjust the resources for the individual. Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) The county of financial responsibility must act on a variable rate request within 30 days and notify the initiator of the request of the county's recommendation in writing.

~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming ~~which~~ that is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; ~~or~~

(4) a demonstrated behavioral or cognitive need that significantly impacts the type or amount of services needed by the individual~~.~~; or

~~(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.~~

~~(d) The facility shall provide an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.~~

~~(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.~~

(5) a demonstrated increased need for staff assistance, changes in the type of staff credentials needed, or a need for expert consultation based on assessments conducted prior to the annual support plan meeting.

(d) Variable rate requests must include the following information:

(1) the service needs change;

(2) the variable rate requested and the difference from the current rate;

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

(4) documentation of the expected outcomes to be achieved and the frequency of progress monitoring associated with the rate increase.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 43. Minnesota Statutes 2020, section 256B.5013, subdivision 6, is amended to read:

Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

(1) make a determination to approve, deny, or modify a request for a variable rate adjustment within 30 days of the receipt of the completed application;

(2) notify the ICF/DD facility and county case manager of the ~~duration and conditions of variable rate adjustment approvals~~ determination; and

(3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved 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.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

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

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

(1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659-; and

(2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on

the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

(k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 29. Minnesota Statutes 2020, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section and section 256B.851, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a financial management services (FMS) provider for a participant to directly employ support workers and purchase supports and goods.

(f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0651;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, clause (3), that replace the need for human assistance.

(h) "Community first services and supports service delivery plan" or "CFSS service delivery plan" means a written document detailing the services and supports chosen by the participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in section 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

(q) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

(r) "Level I behavior" means physical aggression ~~towards~~ toward self or others or destruction of property that requires the immediate response of another person.

(s) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

(t) "Participant" means a person who is eligible for CFSS.

(u) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant or participant's legal representative, if any, to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice and may be withdrawn at any time. The participant's representative must have no financial interest in the provision of any services included in the participant's CFSS service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is

determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

(1) being available while services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;

(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and

(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.

(v) "Person-centered planning process" means a process that is directed by the participant to plan for CFSS services and supports.

(w) "Service budget" means the authorized dollar amount used for the budget model or for the purchase of goods.

(x) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same employer.

(y) "Support worker" means a qualified and trained employee of the agency-provider as required by subdivision 11b or of the participant employer under the budget model as required by subdivision 14 who has direct contact with the participant and provides services as specified within the participant's CFSS service delivery plan.

(z) "Unit" means the increment of service based on hours or minutes identified in the service agreement.

(aa) "Vendor fiscal employer agent" means an agency that provides financial management services.

(bb) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(cc) "Worker training and development" means services provided according to subdivision 18a for developing workers' skills as required by the participant's individual CFSS service delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and

supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 45. Minnesota Statutes 2020, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. **Enhanced rate.** An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ~~12~~ ten or more hours of CFSS per day when provided by a support worker who meets the requirements of subdivision 16, paragraph (e). The enhanced rate for CFSS includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2019, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of CFSS per day.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2020, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that the support worker:

(i) is not disqualified under section 245C.14; or

(ii) is disqualified, but has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) complete the basic standardized CFSS training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. CFSS support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and

responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(5) complete employer-directed training and orientation on the participant's individual needs;

(6) maintain the privacy and confidentiality of the participant; and

(7) not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) does not meet the requirements in paragraph (a);

(2) fails to provide the authorized services required by the employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or by the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 310 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

(e) CFSS qualify for an enhanced rate if the support worker providing the services:

(1) provides services, within the scope of CFSS described in subdivision 7, to a participant who qualifies for ~~12~~ ten or more hours per day of CFSS; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code

of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever occurs later. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 27. **Personal care assistance and community first services and supports provider agency; required reporting and analysis of cost data.** (a) The commissioner must evaluate on an ongoing basis whether the rates paid for personal care assistance and community first services and supports appropriately address the costs to provide these services. The commissioner must make recommendations to adjust the rates paid as indicated by the evaluation. As determined by the commissioner, in consultation with stakeholders, agencies enrolled to provide personal care assistance and community first services and supports with rates determined under this section must submit requested cost data to the commissioner. Requested cost data may include but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs necessary to provide services requested by the commissioner.

(b) At least once in any three-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall give each provider notice 90 days prior to the submission due date. If a provider fails to submit the required reporting data, the commissioner shall provide notice to the provider 30 days after the required submission date, and a second notice to a provider who fails to submit the required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to a provider if the provider fails to submit cost data within

Sec. 30. **[256B.851] COMMUNITY FIRST SERVICES AND SUPPORTS; PAYMENT RATES.**

Subdivision 1. **Application.** (a) The payment methodologies in this section apply to:

(1) community first services and supports (CFSS), extended CFSS, and enhanced rate CFSS under section 256B.85; and

(2) personal care assistance services under section 256B.0625, subdivisions 19a and 19c; extended personal care assistance service as defined in section 256B.0659, subdivision

90 days after the required submission date. The commissioner shall make withheld payments to the provider once the commissioner receives cost data from the provider.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy.

(d) The commissioner, in consultation with stakeholders, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a). The commissioner shall provide dedicated support for providers who meet one of the following criteria:

(1) the provider employs fewer than ten staff to provide the services under this section;

(2) the provider's first language is not English; or

(3) the provider serves a population that includes greater than or equal to 50 percent black people, Indigenous people, or people of color.

Sec. 48. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

Subd. 28. **Payment rates evaluation.** (a) The commissioner shall assess data collected under subdivision 27 and shall publish evaluation findings in a report to the legislature on August 1, 2024, and once every two years thereafter. Evaluation findings shall include:

(1) the costs that providers incur while providing services under this section;

(2) comparisons between those costs and the costs incurred by providers of comparable services and employers in industries competing in the same labor market;

(3) changes in wages, benefits provided, hours worked, and retention over time; and

(4) recommendations for the rate methodologies paid based on the evaluation findings.

(b) The commissioner shall only release cost data in an aggregate form and shall not release cost data from individual providers except as permitted by current law.

EFFECTIVE DATE. This section is effective July 1, 2021.

1; and enhanced rate personal care assistance services under section 256B.0659, subdivision 17a.

(b) This section does not change existing personal care assistance program or community first services and supports policies and procedures.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given in section 256B.85, subdivision 2, and as follows.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means an underlying factor that is built into the rate methodology to calculate service rates and is part of the cost of providing services.

(d) "Payment rate" or "rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

Subd. 3. **Payment rates; base wage index.** When initially establishing the base wage component values, the commissioner must use the Minnesota-specific median wage for the standard occupational classification (SOC) codes published by the Bureau of Labor Statistics in the edition of the Occupational Handbook available January 1, 2021. The commissioner must calculate the base wage component values as follows for:

(1) personal care assistance services, CFSS, extended personal care assistance services, and extended CFSS. The base wage component value equals the median wage for personal care aide (SOC code 31-1120);

(2) enhanced rate personal care assistance services and enhanced rate CFSS. The base wage component value equals the product of median wage for personal care aide (SOC code 31-1120) and the value of the enhanced rate under section 256B.0659, subdivision 17a; and

(3) qualified professional services and CFSS worker training and development. The base wage component value equals the sum of 70 percent of the median wage for registered nurse (SOC code 29-1141), 15 percent of the median wage for health care social worker (SOC code 21-1099), and 15 percent of the median wage for social and human service assistant (SOC code 21-1093).

Subd. 4. **Payment rates; total wage index.** (a) The commissioner must multiply the base wage component values in subdivision 3 by one plus the appropriate competitive workforce factor. The product is the total wage component value.

(b) For personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, and enhanced rate CFSS, the initial competitive workforce factor is 4.7 percent.

(c) For qualified professional services and CFSS worker training and development, the competitive workforce factor is zero percent.

(d) On August 1, 2024, and every two years thereafter, the commissioner shall report recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an update of the competitive workforce factors in this subdivision using the most recently available data. The commissioner shall make adjustments to the competitive workforce factor toward the percent difference between: (1) the median wage for personal care aide (SOC code 31-1120); and (2) the weighted average wage for all other SOC codes with the same Bureau of Labor Statistics classifications for education, experience, and training required for job competency.

(e) The commissioner shall recommend an increase or decrease of the competitive workforce factor from its previous value by no more than three percentage points. If, after a biennial adjustment, the competitive workforce factor is less than or equal to zero, the competitive workforce factor shall be zero.

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

(b) For purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 75.45 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 75.45 percent; and

(3) qualified professional services and CFSS worker training and development: 75.45 percent.

Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine the rate for personal care assistance services, CFSS, extended personal care assistance

services, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) The commissioner must publish the total adjusted payment rates.

Subd. 7. **Personal care provider agency; required reporting and analysis of cost data.** (a) The commissioner shall evaluate on an ongoing basis whether the base wage component values and component values in this section appropriately address the cost to provide the service. The commissioner shall make recommendations to adjust the rate methodology as indicated by the evaluation. As determined by the commissioner and in consultation with stakeholders, agencies enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner. The commissioner may request cost data, including but not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) staff vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any three-year period, a provider must submit the required cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner must provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required cost data, the commissioner must provide notice to a provider that has not provided required cost data 30 days after the required submission date and a second notice to a provider that has not provided required cost data 60 days after the required submission date. The commissioner must temporarily suspend payments to a provider if the commissioner has not received required cost data 90 days after the required submission date. The commissioner must make withheld payments when the required cost data is received by the commissioner.

(c) The commissioner must conduct a random validation of data submitted under this subdivision to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and may submit recommendations on component values, updated base wage component values, and competitive workforce factors to the chair and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance every two years beginning August 1, 2026. The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders, must develop and implement a process for providing training and technical assistance necessary to support provider submission of cost data required under this subdivision.

Subd. 8. **Payment rates; reports required.** (a) The commissioner must assess the standard component values and publish evaluation findings and recommended changes to the rate methodology in a report to the legislature by August 1, 2026.

(b) The commissioner must assess the long-term impacts of the rate methodology implementation on staff providing services with rates determined under this section, including but not limited to measuring changes in wages, benefits provided, hours worked, and retention. The commissioner must publish evaluation findings in a report to the legislature by August 1, 2028, and once every two years thereafter.

Subd. 9. **Self-directed services workforce.** Nothing in this section limits the commissioner's authority over terms and conditions for individual providers in covered programs as defined in section 256B.0711. The commissioner's authority over terms and conditions for individual providers in covered programs remains subject to the state's obligations to meet and negotiate under chapter 179A, as modified and made applicable to individual providers under section 179A.54, and to agreements with any exclusive representative of individual providers, as authorized by chapter 179A, as modified and made applicable to individual providers under section 179A.54. A change in the rate for services within the covered programs defined in section 256B.0711 does not constitute a change in a term or condition for individual providers in covered programs and is not subject to the state's obligation to meet and negotiate under chapter 179A, except that, notwithstanding any other law to the contrary, the state shall meet and negotiate with the exclusive representative of individual providers over wage and benefit increases made possible by rate increases provided between January 1, 2023 and June 30, 2023. Any resulting tentative agreement shall be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 31. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall not enter into agreements for new housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to ~~226~~ 500 supportive housing units in Anoka, Carver, Dakota, Hennepin, ~~or~~ Ramsey, Scott, or Washington County

Sec. 49. Minnesota Statutes 2020, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of housing support beds.** (a) Agencies shall not enter into agreements for new housing support beds with total rates in excess of the MSA equivalent rate except:

(1) for establishments licensed under chapter 245D provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(3) notwithstanding the provisions of subdivision 2a, for up to 226 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental

for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter ~~or discharged from a regional treatment center, community hospital, or residential treatment program and~~, has no appropriate housing available, and lacks the resources and support necessary to access appropriate housing. ~~At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, have been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program.~~ If a person meets the requirements of subdivision 1, paragraph (a) or (b), and receives a federal or state housing subsidy, the housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a~~, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the housing support supplementary service rate~~. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate~~. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a~~;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

(8) for a facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, have been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the housing support rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the housing support supplementary service rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a housing support payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

(4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a housing support contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(5) for a housing support provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a housing support provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(7) for a housing support provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; ~~and~~

(8) for a facility authorized for recipients of housing support in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility

(b) An agency may enter into a housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from housing support payment, or as a result of the downsizing of a setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

(c) The appropriation for this subdivision must include administrative funding equal to the cost of two full-time equivalent employees to process eligibility. The commissioner must disburse administrative funding to the fiscal agent for the counties under this subdivision.

Sec. 32. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the federal Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service

and that until August 1, 2007, operated as a licensed chemical dependency treatment program~~.~~;

(9) for an additional 42 beds, resulting in a total of 54 beds, for a recovery community organization and housing support provider that currently operates a 38-bed facility in Olmsted County serving individuals diagnosed with substance use disorder, originally licensed and registered by the Department of Health under section 157.17 in 2019, and will operate a new 14-bed facility in Olmsted County serving individuals diagnosed with substance use disorder; and

(10) for 46 beds for a recovery community organization and housing support provider that as of March 1, 2021, operates three facilities in Blue Earth County licensed and registered by the Department of Health under section 157.17, serving individuals diagnosed with substance use disorder.

(b) An agency may enter into a housing support agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a housing support agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from housing support payment, or as a result of the downsizing of a setting authorized for recipients of housing support. The transfer of available beds from one agency to another can only occur by the agreement of both agencies.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 50. Minnesota Statutes 2020, section 256I.05, subdivision 1a, is amended to read:

Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04, subdivision 3, the ~~county~~ agency may negotiate a payment not to exceed $426.37 for other services necessary to provide room and board if the residence is licensed by or registered by the Department of Health, or licensed by the Department of Human Services to provide services in addition to room and board, and if the provider of services is not also concurrently receiving funding for services for a recipient under a home and community-based waiver under title XIX of the federal Social Security Act; or funding from the medical assistance program under section 256B.0659, for personal care services for residents in the setting; or residing in a setting which receives funding under section 245.73. If funding is available for other necessary services through a home and community-based waiver, or personal care services under section 256B.0659, then the housing support rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may the supplementary service

rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the ~~county or counties~~ agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to ~~county human service~~ agencies for beds permanently removed from the housing support census under a plan submitted by the ~~county~~ agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 33. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

rate exceed $426.37. The registration and licensure requirement does not apply to establishments which are exempt from state licensure because they are located on Indian reservations and for which the tribe has prescribed health and safety requirements. Service payments under this section may be prohibited under rules to prevent the supplanting of federal funds with state funds. The commissioner shall pursue the feasibility of obtaining the approval of the Secretary of Health and Human Services to provide home and community-based waiver services under title XIX of the federal Social Security Act for residents who are not eligible for an existing home and community-based waiver due to a primary diagnosis of mental illness or chemical dependency and shall apply for a waiver if it is determined to be cost-effective.

(b) The commissioner is authorized to make cost-neutral transfers from the housing support fund for beds under this section to other funding programs administered by the department after consultation with the ~~county or counties~~ agency in which the affected beds are located. The commissioner may also make cost-neutral transfers from the housing support fund to ~~county human service~~ agencies for beds permanently removed from the housing support census under a plan submitted by the ~~county~~ agency and approved by the commissioner. The commissioner shall report the amount of any transfers under this provision annually to the legislature.

(c) ~~Counties~~ Agencies must not negotiate supplementary service rates with providers of housing support that are licensed as board and lodging with special services and that do not encourage a policy of sobriety on their premises and make referrals to available community services for volunteer and employment opportunities for residents.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 51. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

(a) An agency may increase the rates for room and board to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) An agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total housing support rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) An agency must increase the room and board rates ~~will be increased~~ each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences are reported in advance to the county agency's social service staff. Advance reporting is not required for emergency absences due to crisis, illness, or injury. For purposes of maintaining housing while temporarily absent due to residential behavioral health treatment or health care treatment that requires admission to an inpatient hospital, nursing facility, or other health care facility, the room and board rate for an individual is payable beyond an 18-calendar-day absence period, not to exceed 150 days in a calendar year.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

(d) ~~When housing support pays for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences are reported in advance to the county agency's social service staff. Advance reporting is not required for emergency absences due to crisis, illness, or injury.~~

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~~(e) For~~ An agency may increase the rates for residents in facilities meeting substantial change criteria within the prior year. Substantial change criteria ~~exists~~ exist if the establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

~~(f)~~ (e) Until June 30, 1994, an agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to 9549.0058.

(f) Notwithstanding the provisions of subdivision 1, an agency may increase the monthly room and board rates by $100 per month for residents in settings under section 256I.04, subdivision 2a, paragraph (b), clause (2). Participants in the Minnesota supportive housing demonstration program under section 256I.04, subdivision 3, paragraph (a), clause (3), may not receive the increase under this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2022, except the striking of paragraph (d) is effective July 1, 2021.

Sec. 52. Minnesota Statutes 2020, section 256I.05, subdivision 1q, is amended to read:

Subd. 1q. **Supplemental rate; Olmsted County.** (a) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Olmsted County that operates long-term residential facilities with a total of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day supervision and other support services.

(b) Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental service rate for 54 total beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a recovery community organization and housing support provider located in Olmsted County serving individuals diagnosed with substance use disorder, originally licensed and registered by the Department of Health under section 157.17 in 2019.

Sec. 53. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental rate for up to 20 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider located in Douglas County that operates two facilities and provides room and board and supplementary services to adult males recovering from substance use disorder, mental illness, or housing instability.

Sec. 54. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1t. **Supplementary services rate; Winona County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplementary services rate in addition to the monthly room and board rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Winona County that operates a permanent supportive housing facility with 20 one-bedroom apartments for adults with long-term homeless and long-term mental health needs.

Sec. 55. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1u. **Supplemental rate; Blue Earth County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a supplemental service rate for 46 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a recovery community organization and housing support provider that as of March 1, 2021, operates three facilities in Blue Earth County licensed and registered by the Department of Health under section 157.17, serving individuals diagnosed with substance use disorder.

Sec. 56. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 1v. **Supplementary services rate; Steele County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2021, a county agency shall negotiate a

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Sec. 34. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to ~~county human service agencies~~ the agency for emergency shelter beds removed from the housing support census under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. The room and board

supplementary services rate in addition to the monthly room and board rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Steele County that operates a permanent supportive housing facility with 16 units for adults with long-term homeless and long-term mental health needs.

Sec. 57. Minnesota Statutes 2020, section 256I.05, is amended by adding a subdivision to read:

Subd. 2a. **Absent days.** (a) When a person receiving housing support is temporarily absent and the absence is reported in advance to the agency's social service staff, the agency must continue to pay on behalf of the person the applicable rate for housing support. Advance reporting is not required for absences due to crisis, illness, or injury. The limit on payments for absence days under this paragraph is 18 calendar days per incident, not to exceed 60 days in a calendar year.

(b) An agency must continue to pay an additional 74 days per incident, not to exceed a total of 92 days in a calendar year, for a person who is temporarily absent due to admission at a residential behavioral health facility, inpatient hospital, or nursing facility.

(c) If a person is temporarily absent due to admission at a residential behavioral health facility, inpatient hospital, or nursing facility for a period of time exceeding the limits described in paragraph (b), the agency may request in a format prescribed by the commissioner an absence day limit exception to continue housing support payments until the person is discharged.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 58. Minnesota Statutes 2020, section 256I.05, subdivision 11, is amended to read:

Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a cost-neutral transfer of funding from the housing support fund to ~~county human service agencies~~ the agency for emergency shelter beds removed from the housing support census under a biennial plan submitted by the ~~county~~ agency and approved by the commissioner. The plan must describe: (1) anticipated and actual outcomes for persons experiencing homelessness in emergency shelters; (2) improved efficiencies in administration; (3) requirements for individual eligibility; and (4) plans for quality assurance monitoring and quality assurance outcomes. The commissioner shall review the ~~county~~ agency plan to monitor implementation and outcomes at least biennially, and more frequently if the commissioner deems necessary.

(b) The funding under paragraph (a) may be used for the provision of room and board or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated annually, and the room and board portion of the allocation shall be adjusted according to the percentage change in the housing support room and board rate. The room and board

portion of the allocation shall be determined at the time of transfer. The commissioner or ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 35. Minnesota Statutes 2020, section 256S.18, subdivision 7, is amended to read:

Subd. 7. **Monthly case mix budget cap exception.** The commissioner shall approve an exception to the monthly case mix budget cap in ~~paragraph (a)~~ subdivision 3 to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or enhanced rate community first services and supports under section 256B.85. ~~The exception shall not exceed 107.5 percent of the budget otherwise available to the individual.~~ The commissioner must calculate the difference between the rate for personal care assistance services and enhanced rate personal care assistance services. The additional budget amount approved under an exception must not exceed this difference. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2020, section 256S.20, subdivision 1, is amended to read:

Subdivision 1. **Customized living services provider requirements.** ~~Only a provider licensed by the Department of Health as a comprehensive home care provider may provide~~

portion of the allocation shall be determined at the time of transfer. The commissioner or ~~county~~ agency may return beds to the housing support fund with 180 days' notice, including financial reconciliation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 59. Minnesota Statutes 2020, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision ~~1c, paragraph (d)~~ 2a.

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives housing support payments under section 256I.04, subdivision 1, paragraph (c), the amount of the housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective July 1, 2021.

(a) To deliver customized living services or 24-hour customized living services~~.~~, a provider must:

(1) be licensed as an assisted living facility under chapter 144G; or

(2) be licensed as a comprehensive home care provider under chapter 144A and be delivering services: (i) in a setting defined under section 144G.08, subdivision 7, clauses (11) to (13); or (ii) in an affordable housing setting under section 144G.08, subdivision 7, clause (10), that is delivering authorized customized living services to a person in the setting on or before June 30, 2022. A licensed home care provider is subject to section 256B.0651, subdivision 14.

(b) Settings under paragraph (a), clause (2), must comply with section 256S.2003.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 37. **[256S.2003] CUSTOMIZED LIVING SERVICES; REQUIREMENTS OF PROVIDERS IN DESIGNATED SETTINGS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Designated provider" means a home care provider licensed under chapter 144A that provides customized living services to some or all of the residents of a designated setting and that is either the setting itself or another entity with which the setting has a contract or business relationship.

(c) "Designated setting" means a setting defined under section 256S.20, subdivision 1, paragraph (a), clause (2).

(d) "Resident" means a person receiving customized living services in a designated setting.

Subd. 2. **Attestation of compliance with requirements.** Upon enrollment with the department to provide customized living services, a designated provider of customized living services must submit an attestation that the provider is in compliance with subdivisions 3 to 8.

Subd. 3. **Contracts.** (a) Every designated provider must execute a written contract with a resident or the resident's representative and must operate in accordance with the terms of the contract. The resident or the resident's representative must be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

(b) The contract must include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the designated provider;

(2) the name and mailing address of the owner or owners of the designated provider and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the designated provider, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement identifying the designated provider's home care license number;

(6) the term of the contract;

(7) an itemization and description of the services to be provided to the resident;

(8) a conspicuous notice informing the resident of the policy concerning the conditions under which and the process through which the contract may be modified, amended, or terminated;

(9) a description of the designated provider's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(10) the resident's designated representative, if any;

(11) the designated provider's referral procedures if the contract is terminated;

(12) a statement regarding the ability of a resident to receive services from service providers with whom the designated provider does not have an arrangement;

(13) a statement regarding the availability of public funds for payment for residence or services; and

(14) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

(c) The contract must include a statement regarding:

(1) the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) a resident's right to access food at any time;

(3) a resident's right to choose the resident's visitors and times of visits;

(4) a resident's right to choose a roommate if sharing a unit; and

(5) a resident's right to have and use a lockable door to the resident's unit. The designated setting must provide the locks on the unit. Only a staff member with a specific need to enter

the unit shall have keys, and advance notice must be given to the resident before entrance, when possible.

(d) A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under this chapter and section 256B.49 must be documented in the resident's coordinated service and support plan, as defined under sections 256B.49, subdivision 15, and 256S.10.

(e) The contract and related documents executed by each resident or resident's representative must be maintained by the designated provider in files from the date of execution until three years after the contract is terminated.

Subd. 4. **Training in dementia.** (a) If a designated provider has a special program or special care unit for residents with Alzheimer's disease or other dementias or advertises, markets, or otherwise promotes the provision of services for persons with Alzheimer's disease or other dementias, whether in a segregated or general unit, employees of the provider must meet the following training requirements:

(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b), or a supervisor meeting the requirements in clause (1), must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;

(3) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and

(4) new employees may satisfy the initial training requirements under clauses (1) to (3) by producing written proof of previously completed required training within the past 18 months.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The provider must provide to residents and prospective residents in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.

Subd. 5. **Restraints.** Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

Subd. 6. **Termination of contract.** A designated provider must include with notice of termination of contract information about how to contact the ombudsman for long-term care, including the address and telephone number, along with a statement of how to request problem-solving assistance.

Subd. 7. **Manager requirements.** (a) The person primarily responsible for oversight and management of the designated provider, as designated by the owner, must obtain at least 30 hours of continuing education every two years of employment as the manager in topics relevant to the operations of the facility and the needs of its tenants. Continuing education earned to maintain a professional license, such as a nursing home administrator license, nursing license, social worker license, or real estate license, can be used to complete this requirement.

(b) New managers may satisfy the initial dementia training requirements by producing written proof of previously completed required training within the past 18 months.

Subd. 8. **Emergency planning.** (a) Each designated provider must meet the following requirements:

(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in-place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;

(2) prominently post an emergency disaster plan;

(3) provide building emergency exit diagrams to all residents upon signing a contract;

(4) post emergency exit diagrams on each floor; and

(5) have a written policy and procedure regarding missing residents.

(b) Each designated provider must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and

disaster training available to all residents annually. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.

(c) Each designated provider location must conduct and document a fire drill or other emergency drill at least once every six months. To the extent possible, drills must be coordinated with local fire departments or other community emergency resources.

Subd. 9. **Other laws.** Each designated provider must comply with chapter 504B, and must obtain and maintain all other licenses, permits, registrations, or other required governmental approvals. A designated provider is not required to obtain a lodging license under chapter 157 and related rules.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 60. Minnesota Statutes 2020, section 256S.203, is amended to read:

256S.203 CUSTOMIZED LIVING SERVICES; MANAGED CARE RATES.

Subdivision 1. **Capitation payments.** The commissioner ~~shall~~ must adjust the elderly waiver capitation payment rates for managed care organizations paid to reflect the monthly service rate limits for customized living services and 24-hour customized living services established under section 256S.202 and the rate adjustments for disproportionate share facilities under section 256S.205.

Subd. 2. **Reimbursement rates.** Medical assistance rates paid to customized living providers by managed care organizations under this chapter ~~shall~~ must not exceed the monthly service rate limits and component rates as determined by the commissioner under sections 256S.15 and 256S.20 to 256S.202, plus any rate adjustment under section 256S.205.

Sec. 61. **[256S.205] CUSTOMIZED LIVING SERVICES; DISPROPORTIONATE SHARE RATE ADJUSTMENTS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Application year" means a year in which a facility submits an application for designation as a disproportionate share facility.

(c) "Assisted living facility" or "facility" means an assisted living facility licensed under chapter 144G.

(d) "Disproportionate share facility" means an assisted living facility designated by the commissioner under subdivision 4.

Subd. 2. **Rate adjustment application.** An assisted living facility may apply to the commissioner for designation as a disproportionate share facility. Applications must be submitted annually between October 1 and October 31. The applying facility must apply

in a manner determined by the commissioner. The applying facility must document as a percentage the census of elderly waiver participants residing in the facility on October 1 of the application year.

Subd. 3. **Rate adjustment eligibility criteria.** Only facilities with a census of at least 80 percent elderly waiver participants on October 1 of the application year are eligible for designation as a disproportionate share facility.

Subd. 4. **Designation as a disproportionate share facility.** By November 15 of each application year, the commissioner must designate as a disproportionate share facility a facility that complies with the application requirements of subdivision 2 and meets the eligibility criteria of subdivision 3.

Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to $119 per resident per day for 24-hour customized living services provided in a designated disproportionate share facility for the purpose of ensuring the minimal level of staffing required to meet the health and safety need of elderly waiver participants.

(b) The commissioner must adjust the rate floor at least annually in the manner described under section 256S.18, subdivisions 5 and 6.

(c) The commissioner shall not implement the rate floor under this section if the customized living rates established under sections 256S.21 to 256S.215 will be implemented at 100 percent on January 1 of the year following an application year.

Subd. 6. **Budget cap disregard.** The value of the rate adjustment under this section must not be included in an elderly waiver client's monthly case mix budget cap.

EFFECTIVE DATE. This section is effective October 1, 2021, or upon federal approval, whichever is later, and applies to services provided on or after January 1, 2022, or on or after the date upon which federal approval is obtained, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 62. Laws 2019, First Special Session chapter 9, article 5, section 86, subdivision 1, as amended by Laws 2020, First Special Session chapter 2, article 3, section 2, subdivision 1, is amended to read:

Subdivision 1. **Intent.** It is the intent of the legislature to reform the medical assistance waiver programs for people with disabilities to simplify administration of the programs. Disability waiver reconfiguration must incentivize inclusive, person-centered, individualized supports and services; enhance each person's self-determination and personal authority over the person's service choice; align benefits across waivers; ensure equity across programs and populations; assess and address racial and geographical disparities and institutional bias in services and programs; promote long-term sustainability of waiver services; and maintain

service stability and continuity of care while prioritizing, promoting, and creating incentives for independent, integrated, and individualized supports and services chosen by each person through an informed decision-making process and person-centered planning.

Sec. 38. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota, submitted to the Legislative Coordinating Commission on March 1, 2021, is ratified.

Sec. 39. **DIRECTION TO THE COMMISSIONER; CUSTOMIZED LIVING REPORT.**

(a) By January 15, 2022, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's:

(1) assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A;

(2) recommendations regarding the continuation of the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28;

(3) other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

(4) recommendations for needed statutory changes to implement the transition from existing four-person or fewer customized living settings to corporate adult foster care or community residential settings.

(b) The commissioner of health shall provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28. The data must include, at a minimum, each registered housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as a customized living setting to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

Sec. 40. **DIRECTION TO COMMISSIONER; PROVIDER STANDARDS FOR CUSTOMIZED LIVING SERVICES IN DESIGNATED SETTINGS.**

The commissioner of human services shall review policies and provider standards for customized living services provided in settings identified in Minnesota Statutes, section

Sec. 67. **DIRECTION TO COMMISSIONERS; CUSTOMIZED LIVING REPORT.**

(a) By January 15, 2022, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance. The report must include the commissioner's:

(1) assessment of the prevalence of customized living services provided under Minnesota Statutes, section 256B.49, supplanting the provision of residential services and supports licensed under Minnesota Statutes, chapter 245D, and provided in settings licensed under Minnesota Statutes, chapter 245A;

(2) recommendations regarding the continuation of the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28;

(3) other policy recommendations to ensure that customized living services are being provided in a manner consistent with the policy objectives of the foster care licensing moratorium under Minnesota Statutes, section 245A.03, subdivision 7; and

(4) recommendations for needed statutory changes to implement the transition from existing four-person or fewer customized living settings to corporate adult foster care or community residential settings.

(b) The commissioner of health shall provide the commissioner of human services with the required data to complete the report in paragraph (a) and implement the moratorium on home and community-based services customized living settings under Minnesota Statutes, section 256B.49, subdivision 28. The data must include, at a minimum, each registered housing with services establishment under Minnesota Statutes, chapter 144D, enrolled as a customized living setting to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under Minnesota Statutes, section 256B.49.

256S.20, subdivision 1, paragraph (a), clause (2), in consultation with stakeholders. The commissioner may provide recommendations to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over customized living services by February 15, 2022, regarding appropriate regulatory oversight and payment policies for customized living services delivered in these settings.

Sec. 41. **GOVERNOR'S COUNCIL ON AN AGE-FRIENDLY MINNESOTA.**

The Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and private partners' collaborative work on emergency preparedness, with a focus on older adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic. The Governor's Council on an Age-Friendly Minnesota is extended and expires October 1, 2022.

Sec. 63. **PARENTING WITH A DISABILITY; PILOT PROJECT.**

Subdivision 1. **Purpose.** The commissioner of human services shall establish a pilot project to provide grants to personal care assistance provider agencies to provide assistance with child rearing tasks to a parent who is eligible for personal care assistance services under Minnesota Statutes, section 256B.0659, or for services and supports provided through community first services and supports under Minnesota Statutes, section 256B.85. The purpose of this pilot project is to study the benefits of supportive parenting while assisting parents with a disability in child rearing tasks and preventing removal of a child from a parent because the parent has a disability.

Subd. 2. **Definitions.** (a) For the purposes of this section, in addition to the definitions in Minnesota Statutes, section 256B.0659, subdivision 1, applying to the personal care assistance program and the definitions in Minnesota Statutes, section 256B.85, subdivision 2, applying to community first services and supports, the following terms have the meanings given them in this subdivision.

(b) "Adaptive parenting equipment" means a piece of equipment that increases, extends, or improves the parenting capabilities of a parent with a disability.

(c) "Child" means a person under 12 years of age.

(d) "Child rearing task" means a task that assists a parent with a disability to care for a child. Child rearing task includes, but is not limited to: lifting and carrying a child, organizing supplies for a child, preparing meals for a child, washing clothing and bedding for a child, bathing a child, childproofing the home that the parent and child live in, and assisting with transporting a child.

(e) "Commissioner" means the commissioner of human services.

(f) "Parent" means a child's biological, foster, or adoptive parent or legal guardian who is legally obligated to care for and support the child.

(g) "Person with a disability" means an individual who has a physical, mental, or psychological impairment or dysfunction that limits independent functioning in a family, community, or employment.

(h) "Personal care assistant" or "PCA" also means support worker.

(i) "Personal care assistance services" also means the services and supports provided by community first services and supports.

(j) "Supportive parenting assistant" or "SPA" means an individual providing supportive parenting services who is also a personal care assistant.

(k) "Supportive parenting service" means a state-funded service that (1) helps a parent with a disability compensate for aspects of the parent's disability that affect the parent's ability to care for the child, and (2) enables the parent to complete parental responsibilities, including child rearing tasks. Supportive parenting service does not include disciplining the parent's child.

Subd. 3. **Grants.** (a) The commissioner shall develop a competitive application process for up to three two-year state-funded grants to personal care assistance provider agencies to provide supportive parenting services described in subdivision 4 and to purchase adaptive parenting equipment described in subdivision 5. A grant applicant must be a personal care assistance provider agency.

(b) Grant applications must describe how the applicant would recruit families to participate in the pilot project and how the applicant would select families to receive supportive parenting services while giving preference to families in which both parents are receiving personal care assistance services.

(c) Grantees must agree to provide supportive parenting to each selected family for at least one year.

Subd. 4. **Supportive parenting services.** (a) If a parent is eligible for and receiving personal care assistance services, the parent is eligible to receive supportive parenting services funded by a grant under this section. A parent must use one supportive parenting assistant at a time, regardless of the parent's number of children. Supportive parenting services provided under this section are services for the parent and not the child.

(b) An SPA providing supportive parenting services under this section must not perform personal care assistance services while scheduled to provide supportive parenting services. A PCA providing personal care assistance services must not perform supportive parenting services while scheduled to provide personal care assistance services. A PCA providing personal care assistance services and an SPA providing supportive parenting services may be scheduled to support the parent at the same time. The same individual may provide personal care assistance services and supportive parenting assistance to a parent as long as

the requirements of this paragraph are met. Supportive parenting services under this section do not count toward a PCA's 310 hours per-month limit on providing personal care assistance services under Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (a), clause (10).

(c) Supportive parenting services under this section must not replace personal care assistance services.

(d) A parent's supportive parenting services shall be limited to 40 hours per month.

Subd. 5. **Adaptive parenting equipment.** A grantee may purchase adaptive parenting equipment at the request of a parent receiving supportive parenting services under subdivision 4. A grantee must not purchase adaptive parenting equipment covered by medical assistance. A grantee must purchase the least costly item to meet the parent's need.

Sec. 64. **DIRECTION TO THE COMMISSIONER; STUDY OF SUPPORTIVE PARENTING SERVICES.**

The commissioner shall study the feasibility of providing supportive parenting services to parents with disabilities and disabling conditions as a covered medical assistance service and submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services by February 15, 2023. The report must contain at a minimum:

(1) the total number of parents that were provided services through the pilot project;

(2) the total cost of developing and providing the services provided under the pilot project;

(3) recommendations on expansion or continuation of the pilot project;

(4) recommendations on seeking federal approval of supportive parenting services as a covered service under medical assistance; and

(5) draft legislative language.

Sec. 65. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PLAN FOR ADDRESSING EFFECTS ON COMMUNITY OF CERTAIN STATE-OPERATED SERVICES.**

The commissioner of human services, in consultation with stakeholders, shall develop and submit to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by January 31, 2022, a plan to ameliorate the effects of repeated incidents, as defined in Minnesota Statutes, section 245D.02, subdivision 11, occurring at Minnesota state-operated community services programs that affect the community in which the program is located and the neighbors of the service site of the program.

Sec. 66. **DIRECTION TO THE COMMISSIONER; INITIAL PACE IMPLEMENTATION FUNDING.**

The commissioner of human services must work with stakeholders to develop recommendations for financing mechanisms to complete the actuarial work and cover the administrative costs of a program of all-inclusive care for the elderly (PACE). The commissioner must recommend a financing mechanism that could begin July 1, 2023. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care funding by December 15, 2022, on the commissioner's progress toward developing a recommended financing mechanism.

Sec. 68. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DIRECT CARE SERVICES DURING SHORT-TERM ACUTE HOSPITAL VISITS.**

The commissioner of human services, in consultation with stakeholders, shall develop a new covered service under Minnesota Statutes, chapter 256B, or develop modifications to existing covered services, that permits receipt of direct care services in an acute care hospital in a manner consistent with the requirements of United States Code, title 42, section 1396a(h). By August 31, 2022, the commissioner must provide to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over direct care services any draft legislation as may be necessary to implement the new or modified covered service.

Sec. 69. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DRIVING AS COVERED SERVICE UNDER COMMUNITY FIRST SERVICES AND SUPPORTS.**

The commissioner of human services, in consultation with stakeholders and within existing appropriations, shall develop a new covered service under Minnesota Statutes, section 256B.85, that permits a support worker to bill as community first services and supports, not merely assisting a participant with traveling around and participating in the community, or merely accompanying a participant while traveling around or participating in the community, but driving the participant to activities in the community, including to medical appointments. In developing the new covered services, the commissioner must account for any substitution effect that will result from the new covered service supplanting nonemergency medical transportation. By December 31, 2021, the commissioner must provide to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over community first services and supports any draft legislation as may be necessary to implement the new covered service.

Sec. 70. **DIRECTION TO THE COMMISSIONER; LONG-TERM CARE CONSULTATION SERVICE RATES.**

By January 15, 2025, the commissioner of human services shall develop a proposal with legislative language for capitated rates for each type of assessment or activity provided under Minnesota Statutes, section 256B.0911, as determined by the commissioner. The

Sec. 42. **PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES PROVIDED BY A PARENT OR SPOUSE.**

(a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), a parent, stepparent, or legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal care assistance recipient may provide and be paid for providing personal care assistance services.

(b) This section expires upon full implementation and phase-in of the community first services and supports program under Minnesota Statutes, section 256B.85.

EFFECTIVE DATE. This section is effective the day following final enactment or upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 43. **RATE INCREASE FOR DIRECT SUPPORT SERVICES WORKFORCE.**

(a) Effective October 1, 2021, or upon federal approval, whichever is later, if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved pursuant to Minnesota Statutes, section 3.855, the commissioner of human services shall increase:

(1) reimbursement rates, individual budgets, grants, or allocations by 4.14 percent for services under paragraph (b) provided on or after October 1, 2021, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(2) reimbursement rates, individual budgets, grants, or allocations by 2.95 percent for services under paragraph (b) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement;

(3) individual budgets, grants, or allocations by 1.58 percent for services under paragraph (c) provided on or after October 1, 2021, or upon federal approval, whichever is later, to commissioner shall provide the proposal and legislative language to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services policy and finance by January 15, 2025.

Sec. 71. **HOUSING SUPPORT SUPPLEMENTAL SERVICE RATE REDUCTION DELAY.**

The rate reduction described in Minnesota Statutes, section 256B.051, subdivision 7, does not apply until October 1, 2021, for individuals who receive supplemental services from providers that made a good faith effort to become a Medicaid provider by submitting an application by June 1, 2021.

Sec. 72. **PERSONAL CARE ASSISTANCE COMPENSATION FOR SERVICES PROVIDED BY A PARENT OR SPOUSE.**

(a) Notwithstanding Minnesota Statutes, section 256B.0659, subdivisions 3, paragraph (a), clause (1); 11, paragraph (c); and 19, paragraph (b), clause (3), a parent, stepparent, or legal guardian of a minor who is a personal care assistance recipient or a spouse of a personal care assistance recipient may provide and be paid for providing personal care assistance services.

(b) This section expires upon full implementation and phase-in of the community first services and supports program under Minnesota Statutes, section 256B.85.

EFFECTIVE DATE. This section is effective the day following final enactment, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

implement the minimum hourly wage, holiday, and paid time off provisions of that agreement; and

(4) individual budgets, grants, or allocations by .81 percent for services under paragraph (c) provided on or after July 1, 2022, or upon federal approval, whichever is later, to implement the minimum hourly wage, holiday, and paid time off provisions of that agreement.

(b) The rate changes described in paragraph (a), clauses (1) and (2), apply to direct support services provided through a covered program, as defined in Minnesota Statutes, section 256B.0711, subdivision 1, with the exception of consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

(c) The funding changes described in paragraph (a), clauses (3) and (4), apply to consumer-directed community supports available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the federal Social Security Act, and Minnesota Statutes, including but not limited to chapter 256S and sections 256B.092 and 256B.49, and under the alternative care program under Minnesota Statutes, section 256B.0913.

Sec. 44. **WAIVER REIMAGINE PHASE II.**

(a) The commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner of human services may seek all federal authority necessary to implement this section.

EFFECTIVE DATE. This section is effective September 1, 2024, or 90 days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 73. **DIRECTIONS TO THE COMMISSIONER OF HUMAN SERVICES; WAIVER GROWTH LIMITS.**

Subdivision 1. **Community access for disability inclusion waiver growth limit.** Between July 1, 2021, and June 30, 2025, the commissioner shall allocate to county and Tribal agencies money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in forecasted state spending that is equivalent to limiting the caseload growth of the community access for disability inclusion waiver to zero allocations per year. Limits do not apply to conversions from nursing facilities. Counties and Tribal agencies shall manage the annual allocations made by the commissioner to ensure that persons for whom services are temporarily discontinued for no more than 90 days are reenrolled. If a county or Tribal agency fails to meet the authorization and spending requirements under Minnesota Statutes, section 256B.49, subdivision 27, the commissioner may determine a corrective action plan is unnecessary if the failure to meet the requirements is due to managing the annual allocation for the purposes of allowing people to reenroll after their services are temporarily discontinued.

Subd. 2. **Developmental disabilities waiver growth limit.** Between July 1, 2021, and June 30, 2025, the commissioner shall allocate to county and Tribal agencies money for home and community-based waiver programs under Minnesota Statutes, section 256B.092, to ensure a reduction in forecasted state spending that is equivalent to limiting the caseload growth of the developmental disabilities waiver to zero allocations per year. Limits do not apply to conversions from intermediate care facilities for persons with developmental disabilities. Counties and Tribal agencies shall manage the annual allocations made by the commissioner to ensure that persons for whom services are temporarily discontinued for no more than 90 days are reenrolled.

Sec. 74. **RETAINER PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICE PROVIDERS.**

Subdivision 1. **Retainer payments.** (a) The commissioner of human services shall make quarterly retainer payments to eligible recipients by July 1, 2021; September 30, 2021; December 31, 2021; March 31, 2022; and June 30, 2022. The value of the first quarterly payment to each eligible recipient shall be equal to a percentage to be determined by the commissioner under subdivision 9 applied to the eligible recipient's total home and community-based service revenue from medical assistance as of May 31, 2021. The value of each subsequent quarterly payment shall be equal to a percentage to be determined by the commissioner under subdivision 9 applied to the eligible recipient's total home and community-based service revenue from medical assistance based on new data for service claims paid as of the first day of the month in which the retainer payment will be made.

(b) The commissioner shall implement retainer payments and the process of making retainer payments under this subdivision without compliance with time-consuming procedures and formalities prescribed in law, such as the following statutes and related policies:

Minnesota Statutes, sections 16A.15, subdivision 3; 16B.97; 16B.98, subdivisions 5 and 7; and 16B.98, subdivision 8, the express audit clause requirement.

(c) The commissioner's determination of the retainer amount determined under this subdivision is final and is not subject to appeal. This paragraph does not apply to recoupment by the commissioner under subdivision 8.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "direct care professional" means any individual who while providing an eligible service has direct contact with the person receiving the eligible service. Direct care professional excludes executive, managerial, and administrative staff;

(2) "eligible recipient" means an enrolled provider of eligible services, including the Direct Care and Treatment Division at the Department of Human Services, that meets the attestation and agreement requirements in subdivisions 5 and 6;

(3) "eligible service" means a home and community-based service as defined in section 9817(a)(2)(B) of the federal American Rescue Plan Act, Public Law 117-2, except:

(i) community first services and supports;

(ii) extended community first services and supports;

(iii) personal care assistance services;

(iv) extended personal care assistance service;

(v) consumer-directed community supports;

(vi) consumer support grants;

(vii) home health agency services; and

(viii) home care nursing services;

(4) "recipient" means an enrolled provider of an eligible service that receives a retainer payment under this section; and

(5) "total home and community-based service revenue from medical assistance" includes both fee-for-service revenue and revenue from managed care organizations attributable to the provision of eligible services from April 1, 2021, to March 31, 2022. The commissioner shall determine each eligible provider's total home and community-based service revenue from medical assistance based on data for service claims paid as of the date specified in subdivision 9.

Subd. 3. **Allowable uses of funds.** (a) Recipients must use retainer payments to implement one or more of the following activities to enhance, expand, or strengthen home and community-based services:

(1) temporarily increase wages, salaries, and benefits for direct care professionals and any corresponding increase in the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation premiums;

(2) provide hazard pay, overtime pay, and shift differential pay for direct care professionals;

(3) pay for paid sick leave, paid family leave, and paid medical leave due to COVID-19 for direct care professionals;

(4) pay for training for direct care professionals that is specific to the COVID-19 public health emergency;

(5) recruit new direct care professionals;

(6) pay for American sign language and other languages interpreters to assist in providing eligible services or to inform the general public about COVID-19;

(7) purchase emergency supplies and equipment to enhance access to eligible services and to protect the health and well-being of direct care professionals;

(8) support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as personal protective equipment and pay; and

(9) pay for assistive technologies, staffing, and other costs incurred during the COVID-19 public health emergency period to mitigate isolation and ensure an individual's person-centered service plan continues to be fully implemented.

(b) Recipients must:

(1) use at least 50 percent of the additional revenue received in the form of retainer payments for the purposes described in paragraph (a), clauses (1) to (3); and

(2) use any remainder of the additional revenue received in the form of retainer payments for the purposes described in paragraph (a), clauses (4) to (9).

Subd. 4. **Retainer payment requests.** Eligible recipients must request retainer payments under this section no later than June 1, 2022. The commissioner shall develop an expedited request process that includes a form allowing providers to meet the requirements of subdivisions 5 and 6 in as timely a manner as possible. The commissioner shall allow the use of electronic submission of request forms and accept electronic signatures.

Subd. 5. **Attestation.** (a) As a condition of obtaining funds under this section, an eligible recipient must attest to the following on the retainer payment request form:

(1) the intent to provide eligible services through March 31, 2022; and

(2) that the recipient will use the retainer payments only for purposes permitted under this section.

(b) By accepting a retainer payment under this section, the recipient attests to the conditions specified in this subdivision.

Subd. 6. **Agreement.** (a) As a condition of receiving retainer payments under this section, an eligible recipient must agree to the following on the retainer payment request form:

(1) to cooperate with the commissioner of human services to deliver services according to the program and service waivers and modifications issued under the commissioner's authority;

(2) to acknowledge that retention grants may be subject to a special recoupment under this section if a state audit performed under this section determines that the provider used retainer payments for purposes not authorized under this section; and

(3) to acknowledge that a recipient must comply with the distribution requirements described in subdivision 7.

(b) By accepting a retainer payment under this section, the recipient agrees to the conditions specified in this subdivision.

Subd. 7. **Distribution plans.** (a) A recipient must prepare and, upon request, submit to the commissioner, a distribution plan that specifies the anticipated amount and proposed uses of the additional revenue the recipient will receive under this section.

(b) Within 60 days of receipt of the recipient's first retainer payment, the recipient must post the distribution plan and leave it posted for a period of at least six weeks in an area of the recipient's operation to which all direct care professionals have access. The provider must post with the distribution plan instructions on how to contact the commissioner of human services if direct care professionals do not believe they have received the wage increase or benefits required under subdivision 3 specified in the distribution plan. The instructions must include a mailing address, e-mail address, and telephone number that the direct care professional may use to contact the commissioner or the commissioner's representative.

Subd. 8. **Recoupment.** (a) The commissioner may perform an audit under this section up to six years after any retainer payment is made to ensure the funds are utilized solely for the purposes authorized under this section.

(b) If the commissioner determines that a provider used retainer payments for purposes not authorized under this section, the commissioner shall treat any amount used for a purpose

not authorized under this section as an overpayment. The commissioner shall recover any overpayment.

Subd. 9. **Calculation of retainer payments.** (a) The commissioner shall determine a percentage to apply to each recipient's total home and community-based service revenue from medical assistance to calculate the value of each quarterly retainer payment.

(b) The commissioner shall make an estimate of the total projected expenditures for eligible services between April 1, 2021, and March 31, 2022, determine a percentage to be applied to the total projected home and community-based service revenue from medical assistance for all providers of eligible services sufficient to expend the total appropriation for retainer payments, and apply this percentage to each recipient's total home and community-based service revenue from medical assistance on the following schedule:

(1) no earlier than July 1, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on service claims paid as of May 31, 2021;

(2) no later than September 30, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of September 1, 2021, that were not included in the calculation of a prior retainer payment;

(3) no later than December 31, 2021, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of December 1, 2021, that were not included in the calculation of a prior retainer payment; and

(4) no later than March 31, 2022, make a retainer payment by applying the percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of March 1, 2022, that were not included in the calculation of a prior retainer payment.

(c) The commissioner may redetermine the percentage to be applied to each recipient's total home and community-based services revenue from medical assistance.

(d) By June 30, 2022, the commissioner shall redetermine a percentage to be applied to the total home and community-based service revenue from medical assistance based on new service claims paid as of June 1, 2021, that were not included in the calculation of a prior retainer payment. The redetermined percentage must be sufficient to expend the total appropriation for retainer payments. No later than June 30, 2022, the commissioner shall make a final retainer payment by applying the redetermined percentage to each recipient's total home and community-based service revenue from medical assistance based on new service claims paid as of June 1, 2021, that were not included in the calculation of a prior retainer payment.

Sec. 75. **DIRECTION TO THE COMMISSIONER; PERSONAL CARE ASSISTANCE SERVICE RATE INCREASES.**

Effective July 1, 2021, The commissioner of human services shall increase the reimbursement rates, individual budgets, grants, and allocations for community first services and supports under Minnesota Statutes, section 256B.85; personal care assistance services under Minnesota Statutes, section 256B.0659; extended personal care assistance service as defined in Minnesota Statutes, section 256B.0605, subdivision 1, paragraph (g); and extended community first services and supports as defined in Minnesota Statutes, section 256B.85, subdivision 2, paragraph (l); and for budgets of individuals utilizing consumer-directed community supports or participating in the consumer support grant program. The commissioner shall determine the amount of the rate increase to ensure that the state share of the increase does not exceed the amount appropriated in each fiscal year for this purpose in this act.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 76. **DIRECTION TO THE COMMISSIONER; HOME CARE SERVICE RATE INCREASE.**

Effective July 1, 2021, The commissioner of human services shall increase service rates for home health agency services under Minnesota Statutes, section 256B.0653, and for home care nursing services under Minnesota Statutes, section 256B.0654. The commissioner shall determine the amount of the rate increase to ensure that the state share of the increase does not exceed the amount appropriated in this act in each fiscal year for this purpose.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 77. **DIRECTION TO THE COMMISSIONER; ELDERLY WAIVER RATE INCREASE.**

The commissioner of human services shall modify the ratio of the blended rate described under Minnesota Statutes, section 256S.2101, to increase statewide service rates and component service rates. The commissioner shall also adjust service rate limits, monthly service rate limits, and monthly case mix budget caps to accommodate the increased service rates and component service rates established under this section. The commissioner shall modify the blended rates to ensure that the state share of the service rate increase does not exceed the amount appropriated in each fiscal year for this purpose in this act.

Sec. 78. **REVISOR INSTRUCTION.**

(a) The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis, the Office of the House Research Department, and the commissioner of human services, shall prepare legislation for the 2022 legislative session to recodify Minnesota Statutes, sections 256.975, subdivisions 7 to 7d, and 256B.0911.

(b) The revisor of statutes, in consultation with the Office of Senate Counsel, Research and Fiscal Analysis, the Office of the House Research Department, and the commissioner

Sec. 45. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are repealed effective July 1, 2021.

(b) Minnesota Statutes 2020, sections 256B.0916, subdivisions 2, 3, 4, 5, 8, 11, and 12; and 256B.49, subdivisions 26 and 27, are repealed effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

(c) Minnesota Statutes 2020, section 256S.20, subdivision 2, is repealed effective August 1, 2021.

of human services, shall to the greatest extent practicable renumber as subdivisions the paragraphs of Minnesota Statutes, section 256B.4914, prior to the publication of the 2021 Supplement of Minnesota Statutes, and shall without changing the meaning or effect of these provisions minimize the use of internal cross-references, including by drafting new technical definitions as substitutes for necessary cross-references or by other means acceptable to the commissioner of human services.

(c) The revisor of statutes shall change the headnote for Minnesota Statutes, section 256B.097, to read "REGIONAL AND SYSTEMS IMPROVEMENT FOR MINNESOTANS WHO HAVE DISABILITIES."

Sec. 79. **REPEALER.**

(a) Minnesota Statutes 2020, section 256B.4905, subdivisions 1, 2, 3, 4, 5, and 6, are repealed.

(b) Minnesota Statutes 2020, section 256B.097, subdivisions 1, 2, 3, 4, 5, and 6, are repealed.

(c) Laws 2019, First Special Session chapter 9, article 5, section 90, is repealed.