ARTICLE 9

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2020, section 245A.04, is amended by adding a subdivision to read:

Subd. 15b. Additional community residential setting closure requirements. (a) In addition to the requirements in subdivision 15a, in the event that a license holder elects to voluntarily close a community residential setting, the license holder must notify the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care in writing by submitting notification at least 60 days prior to closure. The closure notification must include:

(1) assurance that the license holder notified or will notify residents and their expanded support teams, if applicable, of the closure and comply with the conditions for service terminations under section 245D.10, subdivision 3a;

(2) procedures and actions the license holder will implement to maintain compliance with this subdivision and subdivision 15a; and

(3) assurance that the license holder will meet with the case manager and each resident's expanded support team, as defined in section 245D.02, subdivision 8b, within ten working days of delivering any service terminations to develop a person-centered relocation plan with each individual impacted by the change in service. The license holder must complete a relocation plan for each impacted individual 45 days prior to the service termination or closure date, whichever is sooner;

(b) The commissioner may require the license holder to work with a transitional team that includes department staff, staff of the Office of Ombudsman for Mental Health and Developmental Disabilities, staff of the Office of Ombudsman for Long-Term Care, and other professionals the commissioner deems necessary to assist in the proper relocation of residents.

(c) The commissioner may eliminate a closure rate adjustment under section 256B.493 for violations of this subdivision.

Sec. 2. Minnesota Statutes 2020, section 245D.10, subdivision 3a, is amended to read:

Subd. 3a. Service termination. (a) The license holder must establish policies and procedures for service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person. The policy must include the requirements specified in paragraphs (b) to (f).
The license holder must permit each person to remain in the program or to continue receiving services and must not terminate services unless:

(1) the termination is necessary for the person's welfare and the license holder cannot meet the person's needs;

(2) the safety of the person or others in the program or staff is endangered and positive support strategies were attempted and have not achieved and effectively maintained safety for the person or others;

(3) the health of the person or others in the program would otherwise be endangered;

(4) the program license holder has not been paid for services;

(5) the program or license holder ceases to operate;

(6) the person has been terminated by the lead agency from waiver eligibility; or

(7) for state-operated community-based services, the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1).

Prior to giving notice of service termination, the license holder must document actions taken to minimize or eliminate the need for termination. Action taken by the license holder must include, at a minimum:

(1) consultation with the person's support team or expanded support team to identify and resolve issues leading to issuance of the termination notice;

(2) a request to the case manager for intervention services identified in section 245D.03, subdivision 1, paragraph (c), clause (1), or other professional consultation or intervention services to support the person in the program. This requirement does not apply to notices of service termination issued under paragraph (b), clauses (4) and (7); and

(3) for state-operated community-based services terminating services under paragraph (b), clause (7), the state-operated community-based services must engage in consultation with the person's support team or expanded support team to:

(i) identify that the person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1); and

(ii) provide notice of intent to issue a termination of services to the lead agency when a finding has been made that a person no longer demonstrates complex behavioral needs that cannot be met by private community-based providers identified in section 252.50, subdivision 5, paragraph (a), clause (1);
(iii) assist the lead agency and case manager in developing a person-centered transition plan to a private community-based provider to ensure continuity of care; and

(iv) coordinate with the lead agency to ensure the private community-based service provider is able to meet the person's needs and criteria established in a person's person-centered transition plan.

(4) providing the person, the person's legal representative, and the person's extended support team with:

(i) a statement that the person or the person's legal representative may contact the Office of Ombudsman for Mental Health and Developmental Disabilities or the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination; and

(ii) the telephone number, e-mail address, website address, mailing address, and street address for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

If, based on the best interests of the person, the circumstances at the time of the notice were such that the license holder was unable to take the action specified in clauses (1) and (2), the license holder must document the specific circumstances and the reason for being unable to do so.

The notice of service termination must meet the following requirements:

(1) the license holder must notify the person or the person's legal representative and the case manager in writing of the intended service termination. If the service termination is from residential supports and services as defined in section 245D.03, subdivision 1, paragraph (c), clause (3), the license holder must also notify the commissioner in writing; and

(2) the notice must include:

(i) the reason for the action;

(ii) except for a service termination under paragraph (b), clause (5), a summary of actions taken to minimize or eliminate the need for service termination or temporary service suspension as required under paragraph (c), and why these measures failed to prevent the termination or suspension;

(iii) the person's right to appeal the termination of services under section 256.045, subdivision 3, paragraph (a); and

(iv) the person's right to seek a temporary order staying the termination of services according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c).
(e) Notice of the proposed termination of service, including those situations that began with a temporary service suspension, must be given at least 90 days prior to termination of services under paragraph (b), clause (7), 60 days prior to termination when a license holder is providing intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension under subdivision 3.

(f) During the service termination notice period, the license holder must:

1. work with the support team or expanded support team to develop reasonable alternatives to protect the person and others and to support continuity of care;
2. provide information requested by the person or case manager; and
3. maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

(g) For notices issued under paragraph (b), clause (7), the lead agency shall provide notice to the commissioner and state-operated services at least 30 days before the conclusion of the 90-day termination period, if an appropriate alternative provider cannot be secured. Upon receipt of this notice, the commissioner and state-operated services shall reassess whether a private community-based service can meet the person's needs. If the commissioner determines that a private provider can meet the person's needs, state-operated services shall, if necessary, extend notice of service termination until placement can be made. If the commissioner determines that a private provider cannot meet the person's needs, state-operated services shall rescind the notice of service termination and re-engage with the lead agency in service planning for the person.

(h) For state-operated community-based services, the license holder shall prioritize the capacity created within the existing service site by the termination of services under paragraph (b), clause (7), to serve persons described in section 252.50, subdivision 5, paragraph (a), clause (1).

(1) work with the support team or expanded support team to develop reasonable alternatives to protect the person and others and to support continuity of care;
(2) provide information requested by the person or case manager; and
(3) maintain information about the service termination, including the written notice of intended service termination, in the service recipient record.

(i) For notices issued under paragraph (b), clause (7), the lead agency shall provide notice to the commissioner and state-operated services at least 30 days before the conclusion of the 90-day termination period, if an appropriate alternative provider cannot be secured. Upon receipt of this notice, the commissioner and state-operated services shall reassess whether a private community-based service can meet the person's needs. If the commissioner determines that a private provider can meet the person's needs, state-operated services shall, if necessary, extend notice of service termination until placement can be made. If the commissioner determines that a private provider cannot meet the person's needs, state-operated services shall rescind the notice of service termination and re-engage with the lead agency in service planning for the person.

(ii) For state-operated community-based services, the license holder shall prioritize the capacity created within the existing service site by the termination of services under paragraph (b), clause (7), to serve persons described in section 252.50, subdivision 5, paragraph (a), clause (1).
Section 1. Minnesota Statutes 2020, section 252.275, subdivision 4c, is amended to read:

Subd. 4c. Review of funds; reallocation. (a) After each quarter, the commissioner shall review county program expenditures. The commissioner may reallocate unexpended money at any time among those counties which have earned their full allocation.

(b) For each fiscal year, the commissioner shall determine if actual statewide expenditures by county boards are less than the fiscal year appropriation to provide semi-independent living services under this section. If actual statewide expenditures by county boards are less than the fiscal year appropriation to provide semi-independent living services under this section, the unexpended amount must be carried forward to the next fiscal year and allocated to grants in equal amounts to the eight organizations defined in section 268A.01, subdivision 8, to expand services to support people with disabilities who are ineligible for medical assistance to live in their own homes and communities by providing accessibility modifications, independent living services, and public health program facilitation.

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

Sec. 2. Minnesota Statutes 2020, section 252.275, subdivision 8, is amended to read:

Subd. 8. Use of federal funds and transfer of funds to medical assistance. (a) The commissioner shall make every reasonable effort to maximize the use of federal funds for semi-independent living services.

(b) The commissioner shall reduce the payments to be made under this section to each county from January 1, 1994, to June 30, 1996, by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home and community-based waiver program under section 256B.092 from January 1, 1994, to June 30, 1996, for clients for whom the county is financially responsible and who have been transferred by the county from the semi-independent living services program to the home and community-based waiver program. Unless otherwise specified, all reduced amounts shall be transferred to the medical assistance state account.

(c) For fiscal year 1997, the base appropriation available under this section shall be reduced by the amount of the state share of medical assistance reimbursement for services other than residential services provided under the home and community-based waiver program authorized in section 256B.092 from January 1, 1995, to December 31, 1995, for persons who have been transferred from the semi-independent living services program to the home and community-based waiver program. The base appropriation for the medical assistance state account shall be increased by the same amount.

(d) For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1996 allocations, each county's original allocation for calendar year 1996 shall be reduced by the amount transferred to the state medical assistance account under paragraph (b) during the six months ending on June 30, 1995. For purposes of calculating the guaranteed floor under subdivision 4b and to establish the calendar year 1997 allocations, each county's original allocation for calendar year 1996 shall be reduced by the amount
transferred to the state medical assistance account under paragraph (b) during the six months ending on December 31, 1995.

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

SECTION 32. MINNESOTA STATUTES 2020, SECTION 256.01, AMENDMENT FROM S4410-3, ARTICLE 8, SECTION 32, TO MATCH UES4410-2, ARTICLE 9, SECTION 3.

Subd. 12b. Department of Human Services systemic critical incident review team. (a) The commissioner may establish a Department of Human Services systemic critical incident review team to review critical incident reports as required under section 626.557 for which the Department of Human Services is responsible under section 626.5572, subdivision 13; chapter 245D; or Minnesota Rules, chapter 9544. When reviewing a critical incident, the systemic critical incident review team must identify systemic influences to the incident rather than determining the culpability of any actors involved in the incident. The systemic critical incident review may assess the entire critical incident process from the point of an entity reporting the critical incident through the ongoing case management process.

(b) The Department staff must lead and conduct the reviews and may utilize county staff as reviewers. The systemic critical incident review process may include but is not limited to:

(i) data collection about the incident and actors involved. Data may include the critical incident report under review; previous incident reports pertaining to the person receiving services; the service provider’s policies and procedures applicable to the incident; the coordinated service and support plan as defined in section 245D.02, subdivision 4b, for the person receiving services; or an interview of an actor involved in the critical incident or the review of the critical incident. Actors may include:

(ix) the staff of the provider agency;

(x) lead agency staff administering home and community-based services delivered by the provider;

(xi) Department of Human Services staff with oversight of home and community-based services;

(xii) Department of Health staff with oversight of home and community-based services;

(xiii) members of the community including advocates, legal representatives, health care providers, pharmacy staff, or others with knowledge of the incident or the actors in the incident; and

(xiv) staff from the Office of the Ombudsman for Mental Health and Developmental Disabilities.

(c) The systemic critical incident review team shall identify systemic influences to the incident rather than determining the culpability of any actors involved in the incident. The systemic critical incident review may assess the entire critical incident process from the point of an entity reporting the critical incident through the ongoing case management process.

(d) The Department staff shall lead and conduct the reviews and may utilize county staff as reviewers.

(e) The systemic critical incident review process may include but is not limited to:

(i) data collection about the incident and actors involved. Data may include the critical incident report under review; previous incident reports pertaining to the person receiving services; the service provider’s policies and procedures applicable to the incident; the coordinated service and support plan as defined in section 245D.02, subdivision 4b, for the person receiving services; or an interview of an actor involved in the critical incident or the review of the critical incident. Actors may include:

(ix) the staff of the provider agency;

(x) lead agency staff administering home and community-based services delivered by the provider;

(xi) Department of Human Services staff with oversight of home and community-based services;

(xii) Department of Health staff with oversight of home and community-based services;

(xiii) members of the community including advocates, legal representatives, health care providers, pharmacy staff, or others with knowledge of the incident or the actors in the incident; and

(xiv) staff from the Office of the Ombudsman for Mental Health and Developmental Disabilities.
(2) systemic mapping of the critical incident. The team conducting the systemic mapping of the incident may include any actors identified in clause (1), designated representatives of other provider agencies, regional teams, and representatives of the local regional quality council identified in section 256B.097, and

(3) analysis of the case for systemic influences.

(b) The critical incident review team must aggregate data collected and provide the aggregated data to regional teams, participating regional quality councils, and the commissioner. The regional teams and quality councils must analyze the data and make recommendations to the commissioner regarding systemic changes that would decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

(g) A selection committee must select cases for the systemic critical incident review process from among the following critical incident categories:

(1) cases of caregiver neglect identified in section 626.5572, subdivision 17;

(2) cases involving financial exploitation identified in section 626.5572, subdivision 9;

(3) incidents identified in section 245D.02, subdivision 11;

(4) incidents identified in Minnesota Rules, part 9544.0110; and

(5) service terminations reported to the department in accordance with section 245D.10, subdivision 3a.

(h) The systemic critical incident review under this section must not replace the process for screening or investigating cases of alleged maltreatment of an adult under section 626.557. The department, under the jurisdiction of the commissioner, may select for systemic critical incident review cases reported for suspected maltreatment and closed following initial or final disposition.

(i) The proceedings and records of the review team that are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivisions 3 and 13. Data that document a person's opinions formed as a result of the review are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency arising out of the matters that the team is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because the information, documents, and records were assessed or presented during review team proceedings. A person who presented information before the systemic critical incident review team or who is a member of the team must not be prevented from testifying about matters within the person's knowledge. In a civil or criminal proceeding, a person must not be questioned about opinions formed by the person as a result of the review.
(f) By October 1 of each year, the commissioner shall prepare an annual public report containing the following information:

1. the number of cases reviewed under each critical incident category identified in paragraph (b) and a geographical description of where cases under each category originated;
2. an aggregate summary of the systemic themes from the critical incidents examined by the critical incident review team during the previous year;
3. a synopsis of the conclusions, incident analyses, or exploratory activities taken in regard to the critical incidents examined by the critical incident review team; and
4. recommendations made to the commissioner regarding systemic changes that could decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system.

Sec. 33. Minnesota Statutes 2020, section 256.045, subdivision 3, is amended to read:

Sec. 4. Minnesota Statutes 2020, section 256.045, subdivision 3, is amended to read:
Subd. 3. State agency hearings. (a) State agency hearings are available for the following:
1. any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food and Nutrition Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;
2. any patient or relative aggrieved by an order of the commissioner under section 252.27;
3. a party aggrieved by a ruling of a prepaid health plan;
4. except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;
5. any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under chapter 260E is denied or not acted upon with reasonable promptness, regardless of funding source;
6. any person to whom a right of appeal according to this section is given by other provisions of law;
7. an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;
8. any person to whom a right of appeal according to this section is given by other provisions of law.

By October 1 of each year, the commissioner shall prepare an annual public report containing the following information:

1. the number of cases reviewed under each critical incident category identified in paragraph (b) and a geographical description of where cases under each category originated;
2. an aggregate summary of the systemic themes from the critical incidents examined by the critical incident review team during the previous year;
3. a synopsis of the conclusions, incident analyses, or exploratory activities taken in regard to the critical incidents examined by the critical incident review team; and
4. recommendations made to the commissioner regarding systemic changes that could decrease the number and severity of critical incidents in the future or improve the quality of the home and community-based service system;
(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under chapter 260E, after the individual or facility has exercised the right to administrative reconsideration under chapter 260E;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 245E.06, subdivision 1, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food and Nutrition Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency’s intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, from a licensed provider of any residential supports and services, as defined in paragraph paragraphs (b) and (c), clause (3), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; or

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A
hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 11.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 34.
13. why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 3. [256.4791] COMMUNITY ORGANIZATIONS GRANT PROGRAM.

Subdivision 1. Establishment. The commissioner of human services shall establish the community organizations grant program to address violence prevention and provide street outreach services.

Subd. 2. Applications. Organizations seeking grants under this section shall apply to 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.

Subd. 3. Eligible applicants. To be eligible for a grant under this section, applicants must address violence prevention, connect with youth and community members, and provide street outreach services. Applicants must also be focused on prevention, intervention, and restorative practices within the community, which may include:

(1) providing trauma-responsive care; and
(2) access to individual and group therapy services or community healing.

Subd. 4. Use of grant money. Grant recipients must use the funds to address violence prevention, connect with youth and community members, and provide street outreach services.

Subd. 5. Reporting. Grant recipients must provide an annual report to the commissioner in a manner specified by the commissioner on the activities and outcomes of the project funded by the grant program.

Sec. 4. [256.4792] EMPLOYMENT FOR PERSONS EXPERIENCING HOMELESSNESS OR SUBSTANCE USE DISORDER.

(a) Nonprofit organizations, licensed providers, and other entities that receive funding from the commissioner of human services to address homelessness or provide services to individuals experiencing homelessness must incorporate into their program the facilitation of full- or part-time employment and provide or make available employment services for each client to the extent appropriate for each client.

(b) Nonprofit organizations, licensed providers, and other entities that receive funding from the commissioner of human services to provide substance use disorder services or treatment must incorporate into their program the facilitation of full- or part-time employment and provide or make available employment services for each client to the extent appropriate for each client.
Sec. 5. [256.4795] RESIDENTIAL SETTING CLOSURE PREVENTION GRANTS.

Subdivision 1. Residential setting closure prevention grants established. The commissioner of human services shall establish a grant program to reduce the risk of residential settings in financial distress from closing. The commissioner shall limit expenditures under this subdivision to the amount appropriated for this purpose.

Subd. 2. Definitions. (a) For the purposes of this section, the terms in this subdivision have the meaning given them.

(b) "At risk of closure" or "at risk of closing" means a residential setting is in significant financial distress, and, in the judgment of the commissioner, the setting will close without additional funding from the commissioner.

g) "Residential setting" means any of the following: a nursing facility; an assisted living facility with a majority of residents receiving services funded by medical assistance; a setting exempt from assisted living facility licensure under section 144G.08, subdivision 7, clauses (10) to (13), with a majority of residents receiving services funded by medical assistance; an intermediate care facility for persons with developmental disabilities; or an adult foster care setting, a community residential setting, or an integrated community supports setting.

Subd. 3. Eligibility. (a) A license holder operating a residential setting in significant financial distress may apply to the commissioner for a grant under this section to relieve its immediate financial distress.

(b) Lead agencies that suspect a residential setting is in significant financial distress may refer the license holder to the commissioner for consideration by the commissioner for grant funding under this section. Upon a referral from a lead agency under this section, the commissioner shall immediately solicit an application from the license holder, providing individualized technical assistance to the license holder regarding the application process.

c) The commissioner must give priority for closure prevention grants to residential settings that are the most significantly at risk of closing in violation of the applicable notice requirements prior to the termination of services.

Subd. 4. Criteria and limitations. (a) Within available appropriations for this purpose, the commissioner must award sufficient funding to a residential setting at risk of closure to ensure that the residential setting remains open long enough to comply with the applicable termination of services notification requirements.

(b) The commissioner may award additional funding to a residential setting at risk of closure if, in the judgment of the commissioner, the residential setting is likely to remain open and financially viable after receiving time-limited additional funding from the commissioner.

c) Before receiving any additional funding under paragraph (b), grantees must work with the commissioner to develop a business plan and corrective action plan to reduce the
risk of future financial distress. No residential setting may receive additional funding under paragraph (b) more than once.

Subd. 5. Interagency coordination. The commissioner must coordinate the grant activities under this section with any other impacted state agencies and lead agencies.

Subd. 6. Administrative funding. The commissioner may use up to 6.5 percent of the grant amounts awarded for the commissioner’s costs related to administration of this program.

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

Sec. 5. Minnesota Statutes 2020, section 256B.0651, subdivision 1, is amended to read:

Subdivision 1 Definitions. (a) For the purposes of sections 256B.0651 to 256B.0654 and 256B.0659, the terms in paragraphs (b) to (i) have the meanings given:

(b) "Activities of daily living" has the meaning given in section 256B.0659, subdivision 1, paragraph (b).

(c) "Assessment" means a review and evaluation of a recipient’s need for home care services conducted in person.

(d) "Care coordination" means a service performed by a licensed professional to coordinate both skilled and unskilled home care services, except personal care assistance, for a recipient, and may include documentation and coordination activities not carried out in conjunction with a care evaluation visit.

(e) "Care evaluation" means a start-of-care visit, a resumption-of-care visit, or a recertification visit that is a face-to-face assessment of a person by a licensed professional to develop, update, or review the service plan for both skilled and unskilled home care services, except personal care assistance.

(f) "Home care services" means medical assistance covered services that are home health agency services, including skilled nurse visits; home health aide visits; physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy; home care nursing; and personal care assistance.

(g) "Home residence," effective January 1, 2010, means a residence owned or rented by the recipient either alone, with roommates of the recipient’s choosing, or with an unpaid responsible party or legal representative; or a family foster home where the license holder lives with the recipient and is not paid to provide home care services for the recipient except as allowed under sections 256B.0652, subdivision 10, and 256B.0654, subdivision 4.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Ventilator-dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.
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. 6. Minnesota Statutes 2020, section 256B.0651, subdivision 2, is amended to read:

Subd. 2. Services covered. Home care services covered under this section and sections 256B.0652 to 256B.0654 and 256B.0659 include:

(1) care coordination services under subdivision 1, paragraph (d);
(2) care evaluation services under subdivision 1, paragraph (e);
(3) nursing services under sections 256B.0625, subdivision 6a, and 256B.0653;
(4) home care nursing services under sections 256B.0625, subdivision 7, and 256B.0655;
(5) home health services under sections 256B.0625, subdivision 6a, and 256B.0653;
(6) personal care assistance services under sections 256B.0625, subdivision 19a, and 256B.0654;
(7) supervision of personal care assistance services provided by a qualified professional under sections 256B.0625, subdivision 19a, and 256B.0659;
(8) face-to-face assessments by county public health nurses for services under sections 256B.0625, subdivision 19a, and 256B.0659; and
(9) service updates and review of temporary increases for personal care assistance services by the county public health nurse for services under sections 256B.0625, subdivision 19a, and 256B.0659.

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. 7. Minnesota Statutes 2020, section 256B.0652, subdivision 11, is amended to read:

Subd. 11. Limits on services without authorization. A recipient may receive the following home care services during a calendar year:

(1) up to two face-to-face assessments to determine a recipient's need for personal care assistance services;
(2) one service update done to determine a recipient's need for personal care assistance services; and
(3) up to nine face-to-face visits that may include both skilled nurse visits and care evaluations; and
(4) up to four 15-minute units of care coordination per episode of care to coordinate home health services for a recipient.

**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. 8. Minnesota Statutes 2020, section 256B.0653, subdivision 6, is amended to read:

Subd. 6. Noncovered home health agency services. The following are not eligible for payment under medical assistance as a home health agency service:

1. Telehomecare skilled nurses services that is communication between the home care nurse and recipient that consists solely of a telephone conversation, facsimile, electronic mail, or a consultation between two health care practitioners;

2. The following skilled nurse visits:
   a. For the purpose of monitoring medication compliance with an established medication program for a recipient;
   b. Administering or assisting with medication administration, including injections, prefilling syringes for injections, or oral medication setup of an adult recipient, when, as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient or a family member is physically and mentally able to self-administer or prefill a medication;
   c. Services done for the sole purpose of supervision of the home health aide or personal care assistant;
   d. Services done for the sole purpose to train other home health agency workers;
   e. Services done for the sole purpose of blood samples or lab draw when the recipient is able to access these services outside the home; and
   f. Medicare evaluation or administrative nursing visits required by Medicare, with the exception of care evaluation as defined in section 256B.0651, subdivision 1, paragraph (e);

3. Home health aide visits when the following activities are the sole purpose for the visit: companionship, socialization, household tasks, transportation, and education;

4. Home care therapies provided in other settings such as a clinic or as an inpatient or when the recipient can access therapy outside of the recipient's residence; and

5. Home health agency services without qualifying documentation of a face-to-face encounter as specified in subdivision 7.
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. 9. Minnesota Statutes 2020, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. Definitions. (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression toward self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.


(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services;
communication by telephone and other media; and traveling, including to medical
appointments and to participate in the community. For purposes of this paragraph, traveling
includes driving and accompanying the recipient in the recipient’s chosen mode of
transportation and according to the recipient’s personal care assistance care plan.

438.2 (j) "Managing employee" has the same definition as Code of Federal Regulations, title
42, section 455.

438.8 (k) "Qualified professional" means a professional providing supervision of personal care
assistance services and staff as defined in section 256B.0625, subdivision 19c.

438.10 (l) "Personal care assistance provider agency" means a medical assistance enrolled
provider that provides or assists with providing personal care assistance services and includes
a personal care assistance provider organization, personal care assistance choice agency,
class A licensed nursing agency, and Medicare-certified home health agency.

438.14 (m) "Personal care assistant" or "PCA" means an individual employed by a personal
care assistance agency who provides personal care assistance services.

438.16 (n) "Personal care assistance care plan" means a written description of personal care
assistance services developed by the personal care assistance provider according to the
service plan.

438.19 (o) "Responsible party" means an individual who is capable of providing the support
necessary to assist the recipient to live in the community.

438.21 (p) "Self-administered medication" means medication taken orally, by injection, nebulizer,
or insertion, or applied topically without the need for assistance.

438.23 (q) "Service plan" means a written summary of the assessment and description of the
services needed by the recipient.

438.25 (r) "Wages and benefits" means 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, and contributions to employee retirement accounts.

EFFECTIVE DATE. This section is effective within 90 days following federal approval.

438.30 The commissioner of human services shall notify the revisor of statutes when federal approval
is obtained.

438.31 Sec. 10. Minnesota Statutes 2020, section 256B.0659, subdivision 12, is amended to read:

439.1 Subd. 12. Documentation of personal care assistance services provided. (a) Personal
care assistance services for a recipient must be documented daily by each personal care
assistant, on a time sheet form approved by the commissioner. All documentation may be
web-based, electronic, or paper documentation. The completed form must be submitted on
a monthly basis to the provider and kept in the recipient’s health record.

439.2 May 06, 2022 11:25 AM

439.3 8.7 communication by telephone and other media; and traveling, including to medical
439.4 appointments and to participate in the community. For purposes of this paragraph, traveling
439.5 includes driving and accompanying the recipient in the recipient’s chosen mode of
439.6 transportation and according to the recipient’s personal care assistance care plan.
439.7 (j) "Managing employee" has the same definition as Code of Federal Regulations, title
439.8 42, section 455.
439.9 (k) "Qualified professional" means a professional providing supervision of personal care
439.10 assistance services and staff as defined in section 256B.0625, subdivision 19c.
439.12 (l) "Personal care assistance provider agency" means a medical assistance enrolled
439.13 provider that provides or assists with providing personal care assistance services and includes
439.15 a personal care assistance provider organization, personal care assistance choice agency,
class A licensed nursing agency, and Medicare-certified home health agency.
439.18 (m) "Personal care assistant" or "PCA" means an individual employed by a personal
care assistance agency who provides personal care assistance services.
439.21 (n) "Personal care assistance care plan" means a written description of personal care
439.24 assistance services developed by the personal care assistance provider according to the
439.27 service plan.
439.29 (o) "Responsible party" means an individual who is capable of providing the support
439.31 necessary to assist the recipient to live in the community.
439.33 (p) "Self-administered medication" means medication taken orally, by injection, nebulizer,
or insertion, or applied topically without the need for assistance.
439.35 (q) "Service plan" means a written summary of the assessment and description of the
439.37 services needed by the recipient.
439.39 (r) "Wages and benefits" means 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, and contributions to employee retirement accounts.

EFFECTIVE DATE. This section is effective within 90 days following federal approval.

439.40 The commissioner of human services shall notify the revisor of statutes when federal approval
439.41 is obtained.

439.42 Sec. 7. Minnesota Statutes 2020, section 256B.0659, subdivision 12, is amended to read:

439.43 Subd. 12. Documentation of personal care assistance services provided. (a) Personal
care assistance services for a recipient must be documented daily by each personal care
439.45 assistant, on a time sheet form approved by the commissioner. All documentation may be
439.47 web-based, electronic, or paper documentation. The completed form must be submitted on
439.49 a monthly basis to the provider and kept in the recipient’s health record.
(b) The activity documentation must correspond to the personal care assistance care plan and be reviewed by the qualified professional.

c) The personal care assistant time sheet must be on a form approved by the commissioner documenting time the personal care assistant provides services in the home.

The following criteria must be included in the time sheet:

1. Full name of personal care assistant and individual provider number;
2. Provider name and telephone numbers;
3. Full name of recipient and either the recipient's medical assistance identification number or date of birth;
4. Consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;
5. Signatures of recipient or the responsible party;
6. Personal signature of the personal care assistant;
7. Any shared care provided, if applicable;
8. A statement that it is a federal crime to provide false information on personal care service billings for medical assistance payments; and
9. Dates and location of recipient stays in a hospital, care facility, or incarceration; and
10. Any time spent traveling, as described in subdivision 1, paragraph (i), including start and stop times with a.m. and p.m. designations, the origination site, and the destination site.

EFFECTIVE DATE. This section is effective within 90 days following federal approval.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2021 Supplement, section 256B.0659, subdivision 17a, is amended to read:

Subd. 17a. Enhanced rate. An enhanced rate of 143 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for 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). Any change in the eligibility criteria for the enhanced rate for personal care assistance services as described in this subdivision and referenced in subdivision 11, paragraph (d), shall not constitute a change in a term or condition for which the state is not subject to the state's obligation to meet and negotiate under chapter 179A.
Sec. 9. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

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

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

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

(4) ensure arm's-length transactions without undue influence or coercion with the recipient; and

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

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

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

Subd. 19.

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

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

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

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

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

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

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not

Sec. 11. Minnesota Statutes 2020, section 256B.0659, subdivision 19, is amended to read:

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

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

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

(4) ensure arm's-length transactions without undue influence or coercion with the recipient; and

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

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

(7) use the same personal care assistance choice provider agency if shared personal care assistance care is being used.
limited to, workers' compensation, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective within 90 days following federal approval.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. 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;

limited to, workers' compensation, unemployment insurance, and labor market data required under section 256B.4912, subdivision 1a;

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective within 90 days following federal approval.

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 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;
(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 whose services meet the requirements under subdivision 11, paragraph (d); and
(17) ensure that a personal care assistant driving a recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

**EFFECTIVE DATE.** This section is effective within 90 days following federal approval.

The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 11. [256B.0909] LONG-TERM CARE DECISION REVIEWS.

Subdivision 1. Notice of intent to deny, reduce, suspend, or terminate required. At least ten calendar days prior to issuing a written notice of action, a lead agency must provide in a format accessible to the person or the person's legal representative, if any; a notice of the lead agency's intent to deny, reduce, suspend, or terminate the person's access to or eligibility for:
13.23 (1) home and community-based waivers, including level of care determinations, under sections 256B.092 and 256B.49;
13.24 (2) specific home and community-based services available under sections 256B.092 and 256B.49;
13.25 (3) consumer-directed community supports;
13.26 (4) the following state plan services:
13.27 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;
13.28 (ii) consumer support grants under section 256.476; or
13.29 (iii) community first services and supports under section 256B.85;
14.1 (5) semi-independent living services under section 252.275;
14.2 (6) relocation targeted case management services available under section 256B.0621;
14.3 subdivision 2, clause (4);
14.4 (7) case management services targeted to vulnerable adults or people with developmental disabilities under section 256B.0924;
14.5 (8) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016; and
14.6 (9) necessary diagnostic information to gain access to or determine eligibility under clauses (5) to (8).

Subd. 2. Opportunity to respond required. A lead agency must provide the person, or the person’s legal representative, if any, the opportunity to respond to the agency’s intent to deny, reduce, suspend, or terminate eligibility or access to the services described in subdivision 1. A lead agency must provide the person or the person’s legal representative, if any, ten days to respond. If the person or the person’s legal representative, if any, responds, the agency must initiate a decision review.

Subd. 3. Decision review. (a) A lead agency must initiate a decision review for any person who responds under subdivision 2.
14.18 (b) The lead agency must conduct the decision review in a manner that allows an opportunity for interactive communication between the person and a representative of the lead agency who has specific knowledge of the proposed decision and the basis for the decision. The interactive communication must be in a format that is accessible to the recipient, and may include a phone call, written exchange, in-person meeting, or other format as chosen by the person or the person’s legal representative, if any;
14.21 (c) During the decision review, the representative of the lead agency must provide a thorough explanation of the lead agency’s intent to deny, reduce, suspend, or terminate eligibility or access to the services described in subdivision 1 and provide the person or the
person's legal representative, if any, an opportunity to ask questions about the decision. If the lead agency's explanation of the decision is based on a misunderstanding of the person's circumstances, incomplete information, missing documentation, or similar missing or inaccurate information, the lead agency must provide the person or the person's legal representative, if any, an opportunity to provide clarifying or additional information.

(d) A person with a representative is not required to participate in the decision review. A person may also have someone of the person's choosing participate in the decision review.

Subd. 4. Continuation of services. During the decision review and until the lead agency issues a written notice of action to deny, reduce, suspend, or terminate the eligibility or access, the person must continue to receive covered services.

Subd. 5. Notice of action. Following a decision review, a lead agency may issue a notice of action to deny, reduce, suspend, or terminate the eligibility or access after considering the discussions and information provided during the decision review.

Subd. 6. Appeal rights. Nothing in this section affects a person's appeal rights under section 245.045.

Sec. 13. Minnesota Statutes 2020, section 256B.092, is amended by adding a subdivision to read:

Subd. 15. Community residential setting notice of closure; planning process. (a) The lead agency shall, within five working days of receiving initial notice of a community residential setting's intent to terminate services of a person due to closure pursuant to section 245A.04, subdivision 15b, provide the license holder and the expanded support team with the contact information of those persons responsible for coordinating county and state social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice of closure and proposed closure plan, the county social services agency and license holder shall meet to develop a person-centered relocation plan with each individual impacted by the closure. The license holder shall inform the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care of the date, time, and location of the meeting so that their representatives may attend.

Sec. 12. Minnesota Statutes 2020, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the person-centered written coordinated service and support plan within the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (c). Prior to finalizing the portion of the written coordinated service and support
plan that identifies the amount and frequency of customized living component services to
be provided to the person, if any, the case manager must consider the recommendations of
the provider or proposed provider;

(2) informing the recipient or the recipient's legal guardian or conservator of service
options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers of chosen
services, including:

   (i) available options for case management service and providers;

   (ii) providers of services provided in a non-disability-specific setting;

   (iii) employment service providers;

   (iv) providers of services provided in settings that are not community residential settings;

and

   (v) providers of financial management services;

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

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

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

   (1) finalizing the person-centered coordinated service and support plan;

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

   (3) adjustments to the person-centered coordinated service and support plan.

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

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

1. Phasing out the use of prohibited procedures;
2. Acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and
3. Accomplishment of identified outcomes.

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

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year. The education and training must include person-centered planning and the commissioner's standards and documentation requirements for determining the amount and frequency of customized living component services to be provided to a person. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 1a, paragraph (f).

Sec. 13. Minnesota Statutes 2020, section 256B.49, subdivision 15, is amended to read:

Subd. 15. Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.
(a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b. If the written coordinated service and support plan departs from the recommendations of the provider or proposed provider regarding the amount and frequency of customized living component services to be provided to the person, the case manager must include in the written coordinated service and support plan a written policy or clinical justification for the departure from the recommendations. If a person believes that the amount and frequency of customized living component services identified in the written coordinated service and support plan are not based on the person's assessed needs, preferences, and available resources, the person may appeal under section 256.045, subdivision 3, paragraph (a), clause (6), the amount and frequency of customized living component services to be provided to the person.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication.
process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager 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, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount
Sec. 14. Minnesota Statutes 2020, section 256B.49, is amended by adding a subdivision to read:

Subd. 30. Community residential setting notice of closure; planning process. (a) The lead agency shall, within five working days of receiving initial notice of a community residential setting's intent to terminate services of a person due to closure pursuant to section 245A.04, subdivision 15b, provide the license holder and the expanded support team with the contact information of those persons responsible for coordinating county and state social services agency efforts in the planning process.

(b) Within ten working days of receipt of the notice of closure and proposed closure plan, the county social services agency and license holder shall meet to develop a person-centered relocation plan with each individual impacted by the closure. The license holder shall inform the commissioner, the Office of Ombudsman for Mental Health and Developmental Disabilities, and the Office of Ombudsman for Long-Term Care of the date, time, and location of the meeting so that their representatives may attend.

Sec. 14. [256B.4909] HOME AND COMMUNITY-BASED SERVICES; HOMEMAKER RATES.

Subdivision 1. Application. (a) Notwithstanding any law to the contrary, the payment methodologies for homemaker services defined in this section apply to those homemaker services offered under:

(1) home and community-based services waivers under sections 256B.092 and 256B.49;

(2) alternative care under section 256B.0913;

(3) essential community supports under section 256B.0922; and

(4) elderly waiver, elderly waiver customized living, and elderly waiver foster care under chapter 256S.

(b) This section does not change existing waiver policies and procedures.

Subd. 2. Definition. For purposes of this section, "homemaker services" means homemaker services and assistance with personal care, homemaker services and cleaning, and homemaker services and home management under chapter 256S and similar services offered under home and community-based services waivers under sections 256B.092 and 256B.49; alternative care under section 256B.0913; and essential community supports under section 256B.0922.
Subd. 3. Rate methodology. (a) Beginning January 1, 2023, the rate methodology for each homemaker service must be determined under sections 256S.211, subdivision 1, and 256S.212 to 256S.215, as adjusted by paragraph (b).

(b) As applicable to this section, on November 1, 2024, based on the most recently available wage data by standard occupational classification (SOC) from the Bureau of Labor Statistics, the commissioner shall update for each homemaker service the base wage index in section 256S.212, publish these updated values, and load them into the appropriate rate system.

Subd. 4. Spending requirements. (a) At least 80 percent of the marginal increase in revenue for homemaker services resulting from the implementation of the new rate methodology under this section, including any subsequent rate adjustments, for services rendered on or after the day of implementation of the new rate methodology or applicable rate adjustment must be used to increase compensation-related costs for employees directly employed by the program.

(b) For the purposes of this subdivision; compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes; Medicare taxes; state and federal unemployment taxes; workers' compensation; and mileage reimbursement;

(3) the employer's paid share of health and dental insurance; life insurance; disability insurance; long-term care insurance; uniform allowance; pensions; and contributions to employee retirement accounts; and

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to implementation of the new rate methodology or applicable rate adjustment.

(c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider, or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives additional revenue subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of the new rate methodology or any rate adjustment subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include
instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee has not received the compensation-related increase described in the plan.

Sec. 15. Minnesota Statutes 2020, section 256B.4911, subdivision 3, is amended to read:

Subd. 3. Expansion and increase of budget exceptions. (a) The commissioner of human services must provide up to 30 percent more funds for either:

1. consumer-directed community supports participants under sections 256B.092 and 256B.49 who have a coordinated service and support plan which identifies the need for more services or supports under consumer-directed community supports than the amount the participants are currently receiving under the consumer-directed community supports budget methodology to:

   i. increase the amount of time a person works or otherwise improves employment opportunities;

   ii. plan a transition to, move to, or live in a setting described in section 256D.44, subdivision 5; or

   iii. develop and implement a positive behavior support plan;

2. home and community-based waiver participants under sections 256B.092 and 256B.49 who are currently using licensed providers for: (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet a goal identified in clause (1), item (i), (ii), or (iii). For people moving from a community residential setting to their own home, this exception is no longer available after June 30, 2023, or upon implementation of subdivision 4, paragraph (d), whichever is later.

(b) The exception under paragraph (a), clause (1), is limited to persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for a goal described in paragraph (a), clause (1), item (i), (ii), or (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

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. 16. Minnesota Statutes 2020, section 256B.4911, subdivision 4, is amended to read:

Subd. 4. Budget exception for persons leaving institutions and crisis residential settings. (a) The commissioner must establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under sections 256B.092 and 256B.49. This budget exception process must be available for any individual who:

1. is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

2. requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception paragraph (a) include intermediate care facilities for persons with developmental disabilities, nursing facilities, acute care hospitals, Anoka Metro Regional Treatment Center, Minnesota Security Hospital, and crisis beds.

(c) The budget exception under paragraph (a) must be renewed each year as necessary and consistent with the individual's needs and must be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency must notify the Department of Human Services commissioner of the budget exception.

(d) Consistent with informed choice and informed decision making, the commissioner must establish in the home and community-based services waivers under sections 256B.092 and 256B.49, a consumer-directed community supports budget exception process for individuals living in licensed community residential settings whose cost of residential services may otherwise exceed their available consumer-directed community supports budget. The budget exception process must be available to individuals living in licensed community residential settings who are moving to their own home. This exception is available to people who move from a community residential setting on or after July 1, 2023.

(e) The budget exceptions under paragraph (d) must be renewed each year as necessary and consistent with the individual's needs and must be limited to no more than the cost of the community residential services previously authorized for the individual. The lead agency must notify the commissioner of the budget exception.

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. 17. Minnesota Statutes 2020, section 256B.4911, is amended by adding a subdivision to read:

Subd. 6. Services provided by parents and spouses. (a) Upon federal approval, this subdivision limits medical assistance payments under the consumer-directed community

444.1 Sec. 15. Minnesota Statutes 2020, section 256B.4911, is amended by adding a subdivision
444.2 to read:
444.3 Subd. 6. Services provided by parents and spouses. (a) Upon federal approval, this
444.4 subdivision limits medical assistance payments under the consumer-directed community

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supports option for personal assistance services provided by a parent to the parent's minor child or by a spouse. This subdivision applies to the consumer-directed community supports option available under all of the following:

- (1) alternative care program;
- (2) brain injury waiver;
- (3) community alternative care waiver;
- (4) community access for disability inclusion waiver;
- (5) developmental disabilities waiver;
- (6) elderly waiver; and
- (7) Minnesota senior health option.

(b) For the purposes of this subdivision, "parent" means a parent, stepparent, or legal guardian of a minor.

(c) If multiple parents are providing personal assistance services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. The total number of hours of personal assistance services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(d) If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of personal assistance services in a seven-day period regardless of the number of children served.

(e) If a spouse is providing personal assistance services, the spouse may provide up to 60 hours of personal assistance services in a seven-day period.

(f) This subdivision must not be construed to permit an increase in the total authorized consumer-directed community supports budget for an individual.

EFFECTIVE DATE. This section is effective July 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. 18. Minnesota Statutes 2020, section 256B.4914, subdivision 3, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 3. Applicable services. Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;
(2) adult day services;
(3) adult day services bath;
(4) community residential services;
(5) customized living;
(6) day support services;
(7) employment development services;
(8) employment exploration services;
(9) employment support services;
(10) family residential services;
(11) individualized home supports;
(12) individualized home supports with family training;
(13) individualized home supports with training;
(14) integrated community supports;
(15) night supervision;
(16) positive support services;
(17) prevocational services;
(18) residential support services;
(19) respite services;
(20) transportation services; and
(21) other services as approved by the federal government in the state home and community-based services waiver plan.

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. 19. Minnesota Statutes 2020, section 256B.4914, subdivision 4, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 4. Data collection for rate determination. (a) Rates for applicable home and community-based waivered services, including customized rates under subdivision 12, are set by the rates management system;
(b) Data and information in the rates management system must be used to calculate an individual's rate.

c) Service providers, with information from the coordinated service and support plan and oversight by lead agencies, shall provide values and information needed to calculate an individual's rate in the rates management system. The determination of service levels must be part of a discussion with members of the support team as defined in section 245D.02, subdivision 34. This discussion must occur prior to the final establishment of each individual's rate. The values and information include:

(1) shared staffing hours;
(2) individual staffing hours;
(3) direct registered nurse hours;
(4) direct licensed practical nurse hours;
(5) staffing ratios;
(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;
(7) shared or individualized arrangements for unit-based services, including the staffing ratio;
(8) number of trips and miles for transportation services; and
(9) service hours provided through monitoring technology;

d) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and
(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation;

e) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6 to 9a for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate; and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;
(2) meeting the requirements for staffing under subdivision 2, paragraphs (h), (n), and (o); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

(3) meeting the staffing ratio requirements under subdivision 2, paragraph (o), and meeting or exceeding the licensing standards for staffing required under section 245D.31.

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 2021 Supplement, section 256B.4914, subdivision 5, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 5. Base wage index; establishment and updates. (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 calculating the 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 Occupational Handbook must be used.

(b) The commissioner shall update the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system as follows:

(1) on January 1, 2022, based on wage data by SOC from the Bureau of Labor Statistics available as of December 31, 2019;

(2) on January 1, 2023, based on wage data by SOC from the Bureau of Labor Statistics available as of December 31, 2020;

(3) on November 1, 2024, based on wage data by SOC from the Bureau of Labor Statistics available as of December 31, 2023; and

(4) on July 1, 2026, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics available 24 months and one day prior to the scheduled update.

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. 21. Minnesota Statutes 2021 Supplement, section 256B.4914, subdivision 8, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 8. Unit-based services with programming; component values and calculation of payment rates. (a) For the purpose of this section, unit-based services with programming include employment exploration services, employment development services, employment support services, individualized home supports with family training, individualized home
supports with training, and positive support services provided to an individual outside of any service plan for a day program or residential support service.

(b) 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 support ratio: 15.5 percent;
6. client programming and support ratio: 4.7 percent, updated as specified in subdivision 5b;
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.

(c) A unit of service for unit-based services with programming is 15 minutes.

(d) Payments for unit-based services with programming must be calculated as follows, unless the services are reimbursed separately as part of a residential support services or day program payment rate:

1. determine the number of units of service to meet a recipient's needs;
2. determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;
3. except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;
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 staffing hours by the appropriate staff wage;
6. multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
7. combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;
8. multiply the number of direct staffing hours by the appropriate staff wage;
9. multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
10. combine the results of clauses (8) and (9), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. 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;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, 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 services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six; and

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed three;

(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, 2023, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.4914, subdivision 9, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 9. Unit-based services without programming; component values and calculation of payment rates. (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite.

(b) Component values for unit-based services without programming are:

(1) competitive workforce factor: 4.7 percent;

(2) competitive workforce factor: 4.7 percent;
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29.24

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

29.25

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

29.26

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

29.27

(5) program plan support ratio: 7.0 percent;

29.28

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

29.29

(7) general administrative support ratio: 13.25 percent;

30.1

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

30.2

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

30.3

(c) A unit of service for unit-based services without programming is 15 minutes.

30.4

(d) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

30.5

(1) determine the number of units of service to meet a recipient's needs;

30.6

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 to 5a;

30.7

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

30.8

(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);

30.9

(5) multiply the number of direct staffing hours by the appropriate staff wage;

30.10

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

30.11

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

30.12

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

30.13

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

30.14

(10) for program-related expenses, multiply the result of clause (8) by one plus the program-related expense ratio; and

30.15

(11) for absence and utilization factor, multiply the result of clause (8) by one plus the absence and utilization factor ratio.

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(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, 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 individualized home supports without 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, 2023, or upon federal approval, whichever occurs 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 10, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 10. Evaluation of information and data. (a) The commissioner shall, within available resources, conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state;

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(b) The commissioner, in consultation with stakeholders, shall review and evaluate the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;
(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;
(6) values for workers' compensation as part of employee-related expenses;
(7) values for unemployment insurance as part of employee-related expenses;
(8) direct care workforce labor market measures;
(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services;
(10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section; and
(11) different competitive workforce factors by service, as determined under subdivision 10b.

c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (a) and (b) on January 15, 2021, with a full report, and a full report once every four years thereafter.

d) Beginning July 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

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. 24. Minnesota Statutes 2020, section 256B.4914, subdivision 10a, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 10a. Reporting and analysis of cost data. (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in subdivision 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. 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 required to provide services requested by the commissioner.

(b) At least once in any five-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 provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date; and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy.

(d) The commissioner shall analyze cost data submitted under paragraph (a) and, in consultation with stakeholders identified in subdivision 17, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services once every four years beginning January 1, 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (c).

(e) 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.

(f) The commissioner, in consultation with stakeholders identified in subdivision 17, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

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. 25. Minnesota Statutes 2020, section 256B.4914, subdivision 12, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 12. Customization of rates for individuals. (a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6 to 9a. The customization rate with respect to deaf or hard-of-hearing persons shall be $2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means:

(i) the person has a developmental disability and;

(ii) an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(iii) an expressive communications score that indicates the person uses single signs or gestures; uses an augmentative communication aid; or does not have functional communication; or the person's expressive communications is unknown; and

(iv) a communication score which indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication; or that the person's receptive communication score is unknown; or

(2) the person receives long-term care services and has an assessment score that indicates the person hears only very loud sounds, the person has no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

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. 26. Minnesota Statutes 2020, section 256B.4914, subdivision 14, as amended by Laws 2022, chapter 33, section 1, is amended to read:

Subd. 14. Exceptions. (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (b).
(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

1. An individual has service needs that cannot be met through additional units of service;
2. An individual's rate determined under subdivisions 6 to 9a is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or
3. An individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

1. The service needs required by each individual that are not accounted for in subdivisions 6 to 9a;
2. The service rate requested and the difference from the rate determined in subdivisions 6 to 9a;
3. A basis for the underlying costs used for the rate exception and any accompanying documentation; and
4. Any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256B.045 and 256B.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue
a temporary stay of demission, when requested by the disability waiver recipient, consistent
with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary
stay shall remain in effect until the lead agency can provide an informed choice of
appropriate, alternative services to the disability waiver;

(i) Providers may petition lead agencies to update values that were entered incorrectly
or erroneously into the rate management system, based on past service level discussions
and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's
change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions.
The commissioner shall issue quarterly exceptions statistical reports, including the
number of exception requests received and the numbers granted, denied, withdrawn, and
pending. The report shall include the average amount of time required to process exceptions.

(l) Approved rate exceptions remain in effect in all cases until an individual's needs
change as defined in paragraph (c).

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. 27. Minnesota Statutes 2020, section 256B.493, subdivision 4, is amended to read:

Subd. 4. Review and approval process. (a) To be considered for conditional approval,
an application must include:

1. a description of the proposed closure plan, which must identify the home or homes
and occupied beds for which a planned closure rate adjustment is requested;

2. the proposed timetable for any proposed closure, including the proposed dates for
notification to residents and the affected lead agencies, commencement of closure, and
completion of closure;

3. the proposed relocation plan jointly developed by the counties of financial
responsibility, the residents and their legal representatives, if any, who wish to continue to
receive services from the provider, and the providers for current residents of any adult foster
care home or community residential setting designated for closure; and

4. documentation in a format approved by the commissioner that all the adult foster
care homes or community residential settings receiving a planned closure rate adjustment
under the plan have accepted joint and several liability for recovery of overpayments under
section 256B.0641, subdivision 2; for the facilities designated for closure under this plan

(b) In reviewing and approving closure proposals, the commissioner shall give first
priority to proposals that:
target counties and geographic areas which have:

(i) need for other types of services;

(ii) need for specialized services;

(iii) higher than average per capita use of foster care settings where the license holder
does not reside; or

(iv) residents not living in the geographic area of their choice;

(2) demonstrate savings of medical assistance expenditures; and

(3) demonstrate that alternative services are based on the recipient's choice of provider
and are consistent with federal law, state law, and federally approved waiver plans;

(4) demonstrate alternative services based on the recipient's choices are available and
secured at time of closure application; and

(5) provide proof of referral to the regional Center for Independent Living for resident
transition support.

The commissioner shall also consider prioritize consideration of any information provided
by service recipients, their legal representatives, family members, or the lead agency on the
impact of the planned closure on the recipients and the services they need.

(c) The commissioner shall select proposals that best meet the criteria established in this
subdivision for planned closure of adult foster care or community residential settings. The
commissioner shall notify license holders of the selections conditionally approved by the
commissioner. Approval of closure is obtained following confirmation that every individual
impacted by the planned closure has an established plan to continue services in an equivalent
residential setting or in a less restrictive setting in the community of their choice.

(d) For each proposal conditionally approved by the commissioner, a contract must be
established between the commissioner, the counties of financial responsibility, and the
participating license holder.

Sec. 28. Minnesota Statutes 2020, section 256B.493, subdivision 5, is amended to read:

Subd. 5. Notification of conditionally approved proposal. (a) Once the license holder
receives notification from the commissioner that the proposal has been conditionally
approved, the license holder shall provide written notification within five working days to:

(1) the lead agencies responsible for authorizing the licensed services for the residents
of the affected adult foster care settings; and

(2) current and prospective residents, any legal representatives, and family members
involved.
(b) This notification must occur at least 45–90 days prior to the implementation of the closure proposal.

Sec. 29. Minnesota Statutes 2020, section 256B.493, is amended by adding a subdivision to read:

Subd. 5a. Notification of conditionally approved proposal to Centers for Independent Living. (a) Once conditional approval has been sent to the license holder, the commissioner shall provide written notice within five working days to the regional Center for Independent Living. (b) The commissioner must provide in the written notice the number of persons affected by closure, location of group homes, provider information, and contact information of persons or current guardians to coordinate transition support of residents.

Sec. 30. Minnesota Statutes 2020, section 256B.493, is amended by adding a subdivision to read:

Subd. 5b. Approval for planned closure. The commissioner may finalize approval of conditional applications for planned closure after the license holder takes the following actions and submits proof of documentation to the commissioner:

(1) all parties were provided notice within five business days of receiving conditional approval and residents, support team, and family members were provided 90 days' notice prior to the implementation of the closure proposal;

(2) information regarding rights to appeal service termination and seek a temporary order to stay the termination of services according to the procedures in section 256.045, subdivision 4a or 6, paragraph (c), were provided to the resident, family, and support team at time of closure notice;

(3) residents were provided options to live in the geographic community of their own choice; and

(4) residents were provided options to live in a community residential or own-home setting with the services and supports of their choice.

Sec. 31. Minnesota Statutes 2020, section 256B.493, subdivision 6, is amended to read:

Subd. 6. Adjustment to rates. (a) For purposes of this section, the commissioner shall establish enhanced medical assistance payment rates under sections 256B.092 and 256B.49 to facilitate an orderly transition for persons with disabilities from adult foster care or community residential settings to other community-based settings.

(b) The enhanced payment rate shall be effective the day after the first resident has moved until the day the last resident has moved, not to exceed six months.
Sec. 32. Minnesota Statutes 2020, section 256B.493, is amended by adding a subdivision to read:

Subd. 7. Termination of license or satellite license upon approved closure date. Following approval of a planned closure, the commissioner shall confirm termination of licensure for the residence location, whether satellite or home and community-based license for single residence as referenced in section 245D.23. The commissioner must provide written notice confirming termination of licensure to the provider.

Sec. 33. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision to read:

Subd. 19. ICF/DD rate increase effective July 1, 2022. (a) Effective July 1, 2022, the daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is increased by $50.

(b) Effective July 1, 2022, the daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is increased by $50.

EFFECTIVE DATE. This section is effective July 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. 34. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision to read:

Subd. 20. ICF/DD minimum daily operating payment rates. (a) The minimum daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is $300.

(b) The minimum daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is $400.

EFFECTIVE DATE. This section is effective July 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. 35. Minnesota Statutes 2020, section 256B.5012, is amended by adding a subdivision to read:

Subd. 21. Spending requirements. (a) At least 80 percent of the marginal increase in revenue resulting from implementation of the rate increases under subdivisions 19 and 20 for services rendered on or after the day of implementation of the increases must be used to increase compensation-related costs for employees directly employed by the facility.

(b) For the purposes of this subdivision, compensation-related costs include:

1. wages and salaries;
(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment
taxes, workers' compensation, and mileage reimbursement;  
(3) the employer's paid share of health and dental insurance, life insurance, disability 
insurance, long-term care insurance, uniform allowance, pensions, and contributions to 
employee retirement accounts; and 
(4) benefits that address direct support professional workforce needs above and beyond 
what employees were offered prior to implementation of the rate increases.

(c) Compensation-related costs for persons employed in the central office of a corporation 
or entity that has an ownership interest in the provider or exercises control over the provider,
or for persons paid by the provider under a management contract, do not count toward the 
80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives additional revenue subject to 
the requirements of this subdivision shall prepare, and upon request submit to the 
commissioner, a distribution plan that specifies the amount of money the provider expects 
to receive that is subject to the requirements of this subdivision; including how that money 
was or will be distributed to increase compensation-related costs for employees. Within 60 
days of final implementation of the new rate methodology or any rate adjustment subject 
to the requirements of this subdivision, the provider must post the distribution plan and 
leave it posted for a period of at least six months in an area of the provider's operation to 
which all direct support professionals have access. The posted distribution plan must include 
instructions regarding how to contact the commissioner, or the commissioner's representative, 
if an employee has not received the compensation-related increase described in the plan.

Sec. 36. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 7, is amended 
to read:

Subd. 7. Community first services and supports; covered services. Services and 
supports covered under CFSS include:
(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of 
daily living (IADLs), and health-related procedures and tasks through hands-on assistance 
to accomplish the task or constant supervision and cueing to accomplish the task; 
(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to 
accomplish activities of daily living, instrumental activities of daily living, or health-related 
tasks; 
(3) expenditures for items, services, supports, environmental modifications, or goods, 
including assistive technology. These expenditures must:
(i) relate to a need identified in a participant's CFSS service delivery plan; and

449.1 Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 7, is amended 
to read:
449.2 Subd. 7. Community first services and supports; covered services. Services and 
449.3 supports covered under CFSS include:
449.4 (1) assistance to accomplish activities of daily living (ADLs), instrumental activities of 
449.5 daily living (IADLs), and health-related procedures and tasks through hands-on assistance 
449.6 to accomplish the task or constant supervision and cueing to accomplish the task; 
449.7 (2) assistance to acquire, maintain, or enhance the skills necessary for the participant to 
449.8 accomplish activities of daily living, instrumental activities of daily living, or health-related 
449.9 tasks; 
449.10 (3) expenditures for items, services, supports, environmental modifications, or goods, 
449.11 including assistive technology. These expenditures must:
449.12 (i) relate to a need identified in a participant's CFSS service delivery plan; and
449.13
(ii) increase independence or substitute for human assistance, to the extent that
expenditures would otherwise be made for human assistance for the participant's assessed
needs;

(4) observation and redirection for behavior or symptoms where there is a need for
assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices,
to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision
17, that is under contract with the department and enrolled as a Minnesota health care
program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an
enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal
guardian of a participant under age 18, or who is the participant's spouse.

These support workers shall not:

Covered services under this clause are subject to the limitations described in subdivision 7b; and

(ii) provide any medical assistance home and community-based services in excess of 40
hours per seven-day period regardless of the number of parents providing services,
combination of parents and spouse providing services, or number of children who receive
medical assistance services; and

(iii) have a wage that exceeds the current rate for a CFSS support worker including the
wage, benefits, and payroll taxes; and

(9) worker training and development services as described in subdivision 18a.

EFFECTIVE DATE. This section is effective July 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. 37. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 7a, is amended to read:

Subd. 7a. Enhanced rate. An enhanced rate of 143 percent of the rate paid for
CFSS must be paid for services provided to persons who qualify for ten or more hours of
CFSS per day when provided by a support worker who meets the requirements of subdivision
16; paragraph (e). Any change in the eligibility criteria for the enhanced rate for CFSS as
described in this subdivision and referenced in subdivision 16; paragraph (e), does not
constitute a change in a term or condition for individual providers as defined in section
256B.0711, and is not subject to the state's obligation to meet and negotiate under chapter
179A;
Sec. 38. Minnesota Statutes 2020, section 256B.85, is amended by adding a subdivision to read:

1. Subd. 7b. Services provided by parents and spouses. (a) This subdivision applies to services and supports described in subdivision 7, clause (8).
   (b) If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.
   (c) If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.
   (d) If a spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.
   (e) Paragraphs (b) to (d) must not be construed to permit an increase in either the total authorized service budget for an individual or the total number of authorized service units.
   (f) A parent or spouse must not receive a wage that exceeds the current rate for a CFSS support worker, including the wage, benefits, and payroll taxes.

EFFECTIVE DATE. This section is effective July 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. 20. Minnesota Statutes 2021 Supplement, section 256B.85, subdivision 8, is amended to read:

1. Subd. 8. Determination of CFSS service authorization amount. (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.
   (b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).
   (c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:
   (1) the total number of dependencies of activities of daily living;
   (2) the total number of disabilities or medical conditions;
   (3) the total number of additional service units provided by a support worker; and
   (4) all other factors considered necessary by the commissioner.

EFFECTIVE DATE. This section is effective July 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.
(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior;

(d) The methodology to determine the total service units for CFSS for each home care
rating is based on the median paid units per day for each home care rating from fiscal year
2007 data for the PCA program;

(e) Each home care rating is designated by the letters P through Z and EN and has the
following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs
and qualifies the person for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs
and qualifies the person for six service units;

(3) R home care rating requires a complex health-related need and one to three
dependencies in ADLs and qualifies the person for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies the person
for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior
and qualifies the person for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex
health-related need and qualifies the person for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies the
person for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I
behavior and qualifies the person for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex
health-related need and qualifies the person for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651,
subdivision 1, paragraph (i). A person who meets the definition of ventilator-dependent
and the EN home care rating and utilize a combination of CFSS and home care nursing
services is limited to a total of 96 service units per day for those services in combination.
Additional units may be authorized when a person's assessment indicates a need for two
staff to perform activities. Additional time is limited to 16 service units per day;

(f) Additional service units are provided through the assessment and identification of
the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily
living.
(2) 30 additional minutes per day for each complex health-related need; and
(3) 30 additional minutes per day for each behavior under this clause that requires
assistance at least four times per week:
   (i) level I behavior that requires the immediate response of another person;
   (ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
   or
   (iii) increased need for assistance for participants who are verbally aggressive or resistive
to care so that the time needed to perform activities of daily living is increased;

(g) The service budget for budget model participants shall be based on:
   (1) assessed units as determined by the home care rating; and
   (2) an adjustment needed for administrative expenses;

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. 39. Minnesota Statutes 2021 Supplement, section 256B.851, subdivision 5, is amended
to read:

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

(1) employee vacation, sick, and training factor, 8.71 percent;
(2) employer taxes and workers’ compensation factor, 11.56 percent;
(3) employee benefits factor, 12.04 percent;
(4) client programming and supports factor, 2.30 percent;
(5) program plan support factor, 7.00 percent;
(6) general business and administrative expenses factor, 13.25 percent;
(7) program administration expenses factor, 2.90 percent; and
(8) absence and utilization factor, 3.90 percent.

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

(1) personal care assistance services and CFSS: 79.5 percent;
(2) enhanced rate personal care assistance services and enhanced rate CFSS: 79.5 percent; and

(1) personal care assistance services and CFSS: 83.5 percent;
(2) enhanced rate personal care assistance services and enhanced rate CFSS: 83.5 percent; and
(3) qualified professional services and CFSS worker training and development: 454.15.

EFFECTIVE DATE. This section is effective January 1, 2023, or 60 days following 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 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, Carver, Dakota, Hennepin, or Ramsey, Scott, or Washington County for homeless adults with a disability, including but not limited to mental illness, a history of substance abuse, 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, 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, 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 service rate for that 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 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, Carver, Dakota, Hennepin, or Ramsey, Scott, or Washington County for homeless adults with a disability, including but not limited to mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome.
provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256L.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.

(b) An agency may enter into a housing support agreement for 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.

(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.

(b) An agency may enter into a housing support agreement for 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.

Sec. 41. Minnesota Statutes 2020, section 256L.05, is amended by adding a subdivision to read:

Subd. 1a. Supplemental rate; Douglas County. Notwithstanding the provisions in this section, 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.

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

75.12 Sec. 15. Minnesota Statutes 2020, section 256S.16, is amended to read:

Subd. 1. Service rates; generally. A lead agency must use the service rates and
service rate limits published by the commissioner to authorize services.

Subd. 2. Shared services; rates. The commissioner shall establish a rate system for
shared homemaker services and shared chore services, based on homemaker rates for a
single individual under section 256S.215, subdivisions 9 to 11, and the chore rate for a
single individual under section 256S.215, subdivision 7. For two persons sharing services,
the rate paid to a provider must not exceed 1-1/2 times the rate paid for serving a single
individual, and for three persons sharing services, the rate paid to a provider must not exceed
two times the rate paid for serving a single individual. These rates apply only when all of
the criteria for the shared service have been met.

Subd. 3. Case mix classifications. (a) The elderly waiver case mix classifications
A to K shall be the resident classes A to K established under Minnesota Rules, parts
9549.0058 and 9549.0059.

(b) A participant assigned to elderly waiver case mix classification A must be reassigned
to elderly waiver case mix classification L if an assessment or reassessment performed
under section 256B.0911 determines that the participant has:

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

(2) up to two dependencies in bathing, dressing, grooming, walking, or eating when the
dependency score in eating is three or greater.

(c) A participant must be assigned to elderly waiver case mix classification V if the
participant meets the definition of ventilator-dependent in section 256B.0651; subdivision
1, paragraph (i).
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. 42. Laws 2014, chapter 312, article 27, section 75, is amended to read:

Sec. 75. PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2014.

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by five percent for the rate period beginning July 1, 2014, for services rendered on or after July 1, 2014. County or tribal contracts for services, grants, and programs under paragraph (b) must be amended to pass through these rate increases by September 1, 2014.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities, including consumer-directed community supports, under Minnesota Statutes, section 256B.092;

(2) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) community first services and supports under Minnesota Statutes, section 256B.85;

(10) essential community supports under Minnesota Statutes, section 256B.0922;

(11) day training and habilitation services for adults with developmental disabilities under Minnesota Statutes, sections 252.41 to 252.46; including the additional cost to counties of the rate adjustments on day training and habilitation services provided as a social service.
(12) alternative care services under Minnesota Statutes, section 256B.0913;
(13) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;
(14) semi-independent living services (SILS) under Minnesota Statutes, section 252.275;
(15) consumer support grants under Minnesota Statutes, section 256.476;
(16) family support grants under Minnesota Statutes, section 252.32;
(17) housing access grants under Minnesota Statutes, section 256B.0658;
(18) self-advocacy grants under Laws 2009, chapter 101;
(19) technology grants under Laws 2009, chapter 79;
(20) aging grants under Minnesota Statutes, sections 256.975 to 256.977 and 256B.0917;
(21) deaf and hard-of-hearing grants, including community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2;
(22) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233, 256C.25, and 256C.261;
(23) Disability Linkage Line grants under Minnesota Statutes, section 256.01, subdivision 24;
(24) transition initiative grants under Minnesota Statutes, section 256.478;
(25) employment support grants under Minnesota Statutes, section 256B.021, subdivision 6; and
(26) grants provided to people who are eligible for the Housing Opportunities for Persons with AIDS program under Minnesota Statutes, section 256B.492;
(e) A managed care plan or county-based purchasing plan receiving state payments for the services grants and programs in paragraph (b) must include these increases in their payments to providers. To implement the rate increase in paragraph (a), capitation rates paid by the commissioner to managed care plans and county-based purchasing plans under Minnesota Statutes, section 256B.69, shall reflect a five percent increase for the services and programs specified in paragraph (b) for the period beginning July 1, 2014;
(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amount in paragraph (a) on July 1, 2014;
(e) To receive the rate increase described in this section, providers under paragraphs (a) and (b) must submit to the commissioner documentation that identifies a quality improvement project that the provider will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must
(1) improve the quality of life of home and community-based services recipients in a meaningful way;
(2) improve the quality of services in a measurable way; or
(3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

Providers listed in paragraph (b), clauses (7), (9), (10), and (13) to (26), are not subject to this requirement.

(f) For a provider that fails to submit documentation described in paragraph (e) by a date or in a format specified by the commissioner, the commissioner shall reduce the provider's rate by one percent effective January 1, 2015.

(g) Providers that receive a rate increase under paragraph (a) shall use 80 percent of the additional revenue to increase compensation-related costs for employees directly employed by the program on or after July 1, 2014, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider; and
(2) persons paid by the provider under a management contract.

This requirement is subject to audit by the commissioner.

(b) Compensation-related costs include:

(1) wages and salaries;
(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;
(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and
(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (m);

(i) For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases for public employees under paragraph (g) must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

(j) For a provider that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan required under paragraph (m), in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to
have met all the requirements of this section in regard to the members of the bargaining
unit. Upon request, the provider shall produce the letter of acceptance for the commissioner.

(k) The commissioner shall amend state grant contracts that include direct
personnel-related grant expenditures to include the allocation for the portion of the contract
related to employee compensation. Grant contracts for compensation-related services must
be amended to pass through these adjustments by September 1, 2014, and must be retroactive
to July 1, 2014.

(l) The Board on Aging and its area agencies on aging shall amend their grants that
include direct personnel-related grant expenditures to include the rate adjustment for the
portion of the grant related to employee compensation. Grants for compensation-related
services must be amended to pass through these adjustments by September 1, 2014, and
must be retroactive to July 1, 2014.

(m) A provider that receives a rate adjustment under paragraph (a) that is subject to
paragraph (g) shall prepare, and upon request submit to the commissioner, a distribution
plan that specifies the amount of money the provider expects to receive that is subject to
the requirements of paragraph (g), including how that money will be distributed to increase
compensation for employees. The commissioner may recover funds from a provider that
fails to comply with this requirement.

(n) By January 1, 2015, the provider shall post the distribution plan required under
paragraph (m) for a period of at least six weeks in an area of the provider's operation to
which all eligible employees have access and shall provide instructions for employees who
do not believe they have received the wage and other compensation-related increases
specified in the distribution plan. The instructions must include a mailing address, e-mail
address, and telephone number that the employee may use to contact the commissioner or
the commissioner's representative.

(o) For providers with rates established under Minnesota Statutes, section 256B.4914,
and with a historical rate established under Minnesota Statutes, section 256B.4913,
subdivision 4a, paragraph (b), that is greater than the rate established under Minnesota
Statutes, section 256B.4914, the requirements in paragraph (g) must only apply to the portion
of the rate increase that exceeds the difference between the rate established under Minnesota
Statutes, section 256B.4914, and the banding value established under Minnesota Statutes,
section 256B.4913, subdivision 4a, paragraph (b).

Sec. 43. Laws 2021, First Special Session chapter 7, article 17, section 14, is amended to
read:

TASK FORCE ON ELIMINATING SUBMINIMUM WAGES.

Subdivision 1. Establishment; purpose. The Task Force on Eliminating Subminimum
Wages is established to develop a plan and make recommendations to phase out payment
of subminimum wages to people with disabilities on or before August 1, 2025.
Sec. 25. Laws 2021, First Special Session chapter 7, article 17, section 14, subdivision 3, is amended to read:

Subd. 3. Membership. (a) The task force consists of 16 members, appointed as follows:

1. the commissioner of human services or a designee;
2. the commissioner of labor and industry or a designee;
3. the commissioner of education or a designee;
4. the commissioner of employment and economic development or a designee;
5. a representative of the Department of Employment and Economic Development's Vocational Rehabilitation Services Division appointed by the commissioner of employment and economic development;
6. one member appointed by the Minnesota Disability Law Center;
7. one member appointed by The Arc of Minnesota;
8. four members who are persons with disabilities appointed by the commissioner of human services, at least one of whom must have a significant physical disability, and at least one of whom must have a neurodiverse, and at least one of whom must have a significant physical disability and at least one of whom at the time of the appointment is being paid a subminimum wage;
9. two representatives of employers authorized to pay subminimum wage and one representative of an employer who successfully transitioned away from payment of subminimum wages to people with disabilities, appointed by the commissioner of human services;
10. one member appointed by the Minnesota Organization for Habilitation and Rehabilitation;
11. one member appointed by ARRM and
12. one member appointed by the State Rehabilitation Council and
13. three members who are parents or guardians of persons with disabilities appointed by the commissioner of human services, at least one of whom is a parent or guardian of a person who is neurodiverse, at least one of whom is a parent or guardian of a person with

Subd. 2. Definitions. For the purposes of this section, "subminimum wage" means wages authorized under section 14(c) of the federal Fair Labor Standards Act, Minnesota Statutes, section 177.28, subdivision 5, or Minnesota Rules, parts 5200.0030 and 5200.0040.
a significant physical disability, and at least one of whom is a parent or guardian of a person being paid a subminimum wage as of the date of the appointment.

(b) To the extent possible, membership on the task force under paragraph (a) shall reflect geographic parity throughout the state and representation from Black, Indigenous, and communities of color.

**EFFECTIVE DATE.** This section is effective the day following final enactment. The commissioner of human services must make the additional appointments required under this section within 30 days following final enactment.

Subd. 4. **Appointment deadline; first meeting; chair.** Appointing authorities must complete member selections by January 1, 2022. The commissioner of human services shall convene the first meeting of the task force by February 15, 2022. The task force shall select a chair from among its members at its first meeting.

Subd. 5. **Compensation.** Members shall be compensated and may be reimbursed for expenses as provided in Minnesota Statutes, section 15.059, subdivision 3.

Subd. 6. **Duties; plan and recommendations.** The task force shall:

1. develop a plan to phase out the payment of subminimum wages to people with disabilities by August 1, 2025; promote independence and increase opportunities for people with disabilities to earn competitive wages;
2. consult with and advise the commissioner of human services on statewide plans for limiting reducing reliance on subminimum wages in medical assistance home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49;
3. engage with employees with disabilities paid subminimum wages and conduct community education on the payment of subminimum wages to people with disabilities in Minnesota;
4. identify and collaborate with employees, employers, businesses, organizations, agencies, and stakeholders impacted by the phase out of subminimum wage on how to implement the plan and create sustainable work opportunities for employees with disabilities;
5. propose a plan to establish and evaluate benchmarks for measuring annual progress toward eliminating reducing reliance on subminimum wages;
6. propose a plan to monitor and track outcomes of employees with disabilities, including those who transition to competitive employment;
7. identify initiatives, investment, training, and services designed to improve wages, reduce unemployment rates, and provide support and sustainable work opportunities for persons with disabilities;
53.8 (8) identify benefits to the state in eliminating in reducing reliance on subminimum wage by August 1, 2025 wages;
53.9 (9) identify barriers to eliminating subminimum wage by August 1, 2025 wages, including the cost of implementing and providing ongoing employment services, training, and support for employees with disabilities and the cost of paying minimum wage wages to employees with disabilities; and the potential impact on persons with disabilities who would be unable to find sustainable employment in the absence of a subminimum wage or who would not choose competitive employment;
53.10 (10) make recommendations to eliminate the barriers identified in clause (9); and
53.11 (11) identify and make recommendations for sustainable financial support, funding, and resources for eliminating reducing reliance on subminimum wage by August 1, 2025 wages.
53.12 Subd. 7. Duties; provider reinvention grants. (a) The commissioner of human services shall establish a provider reinvention grant program to promote independence and increase opportunities for people with disabilities to earn competitive wages. The commissioner shall make the grants available to at least the following:
53.13 (1) providers of disability services under Minnesota Statutes, sections 256B.092 and 256B.49, for developing and implementing a business plan to shift the providers' business models away from paying waiver participants subminimum wages;
53.14 (2) organizations to develop peer-to-peer mentoring for people with disabilities who have successfully transitioned to earning competitive wages;
53.15 (3) organizations to facilitate provider-to-provider mentoring to promote shifting away from paying employees with disabilities a subminimum wage; and
53.16 (4) organizations to conduct family outreach and education on working with people with disabilities who are transitioning from subminimum wage employment to competitive employment.
53.17 (b) The provider reinvention grant program must be competitive. The commissioner of human services must develop criteria for evaluating responses to requests for proposals.
53.18 Criteria for evaluating grant applications must be finalized no later than November 1, 2021. The commissioner of human services shall administer grants in compliance with Minnesota Statutes, sections 16B.97 and 16B.98, and related policies set forth by the Department of Administration's Office of Grants Management.
53.19 (c) Grantees must work with the commissioner to develop their business model and, as a condition of receiving grant funds, grantees must fully phase out the use of subminimum wage by April 1, 2024, unless the grantee receives a waiver from the commissioner of human services for a demonstrated need.
(d) Of the total amount available for provider reinvention grants, the commissioner may award up to 25 percent of the grant funds to providers who have already successfully shifted their business model away from paying employees with disabilities subminimum wages to provide provider-to-provider mentoring to providers receiving a provider reinvention grant.

Subd. 8. Report. By February 15, 2023, the task force shall submit to the chairs and ranking minority members of the committees and divisions in the senate and house of representatives with jurisdiction over employment and wages and over health and human services a report with recommendations to eliminate by August 1, 2025, the payment of subminimum wage, increase opportunities for people with disabilities to earn competitive wages, and any changes to statutes, laws, or rules required to implement the recommendations of the task force. The task force must include in the report a recommendation concerning continuing the task force beyond its scheduled expiration.

Subd. 9. Administrative support. The commissioner of human services shall provide meeting space and administrative services to the task force.

Subd. 10. Expiration. The task force shall conclude their duties and expire on March 31, 2024.

EFFECTIVE DATE. This section is effective the day following final enactment. The commissioner of human services must make the additional appointments required under this section within 30 days following final enactment.

Sec. 44. Laws 2022, chapter 33, section 1, subdivision 5a, is amended to read:

Subd. 5a. Base wage index; calculations. The base wage index must be calculated as follows:

1. 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 specialist, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);
2. For registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141);
3. For licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061);
4. For residential asleep-overnight staff, the minimum wage in Minnesota for large employers, with the exception of asleep-overnight staff for family residential services, which is 36 percent of the minimum wage in Minnesota for large employers;
5. For residential direct care staff, the sum of:
(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant aide (SOC code 31-1131); and 20 percent of the median wage for social and human services aide (SOC code 31-1123); and

(ii) 85 percent of the subtotal of 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant aide (SOC code 31-1131); 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);

6 for adult day services staff, 70 percent of the median wage for nursing assistant (SOC code 31-1131); and 30 percent of the median wage for home health and personal care aide (SOC code 31-1120);

7 for day support services staff and prevocational services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1131); 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);

8 for positive supports analyst staff, 100 percent of the median wage for substance abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

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

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

11 for individualized home supports with family training staff, 20 percent of the median wage for psychiatric aide (SOC code 31-1131); 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 technologist (SOC code 29-2053);

12 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);

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);
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. 45. Laws 2022, chapter 33, section 1, subdivision 5b, is amended to read:

Subd. 5b. Standard component value adjustments. The commissioner shall update the client and programming support, transportation, and program facility cost component values as required in subdivisions 6 to 9a for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower, publish these updated values, and load them into the rate management system as follows:

(1) on January 1, 2022, by the percentage change in the CPI-U from the date of the previous update to the data available on December 31, 2019;

(2) on January 1, 2023, by the percentage change in the CPI-U from the date of previous update to the data available on December 31, 2021;

(3) on November 1, 2024, January 1, 2025, by the percentage change in the CPI-U from the date of the previous update to the data available as of December 31, 2023, and every two years thereafter, by the percentage change in the CPI-U from the date of the previous update to the data available 12 months and one day prior to the scheduled update.

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. 46. Laws 2022, chapter 33, section 1, subdivision 5c, is amended to read:

Subd. 5c. Removal of after-framework adjustments. 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 subdivisions 5 and 5b, and 5f.

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. 47. Laws 2022, chapter 33, section 1, subdivision 5d, is amended to read:

Subd. 5d. Unavailable data for updates and adjustments. If Bureau of Labor Statistics occupational codes or Consumer Price Index items specified in subdivisions 5 or 5b, or 5f are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace.

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. 48. Laws 2022, chapter 33, section 1, subdivision 5e, is amended to read:

Subd. 5e. Inflationary update spending requirement. (a) At least 80 percent of the marginal increase in revenue from the rate adjustment applied to the service rates calculated under subdivisions 5 and 5b beginning on January 1, 2022, for services rendered between January 1, 2022, and March 31, 2024, must be used to increase compensation-related costs for employees directly employed by the program on or after January 1, 2022.

(b) For the purposes of this subdivision, compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's paid share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to January 1, 2022, implementation of the applicable rate adjustment, including retention and recruitment bonuses and tuition reimbursement.

(c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider,
or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives a rate subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision; including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of a rate adjustment subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner or commissioner's representative if an employee believes the employee has not received the compensation-related increase described in the plan.

(e) This subdivision expires June 30, 2024. At least 80 percent of the marginal increase in revenue from the rate adjustments applied to service rates calculated under subdivisions 5, 5b, and 5f beginning on January 1, 2023, and on January 1, 2025, for services rendered on or after those dates must be used to increase compensation-related costs for employees directly employed by the program.

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. 49. Laws 2022, chapter 33, section 1, is amended by adding a subdivision to read:

Subd. 5f. Competitive workforce factor adjustments. (a) On January 1, 2023, and every two years thereafter, the commissioner shall update the competitive workforce factor to equal the differential between:

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; and

2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations.

(b) For each update of the competitive workforce factor, the update shall not decrease the competitive workforce factor by more than 2.0. If the competitive workforce factor is less than or equal to zero, then the competitive workforce factor is zero.

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. 27. Laws 2022, chapter 33, section 1; subdivision 9a, is amended to read:

Subd. 9a. Respite services; component values and calculation of payment rates. (a)

460.9 For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service;

(b) Component values for respite 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: 2.9 percent; and
(7) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;
(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;
(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;
(4) 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 (3);
(5) multiply the number of direct staffing hours by the appropriate staff wage;
(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;
(8) for employee-related expenses, multiply the result of clause (7) by one plus the
employee-related cost ratio;

(9) this is the subtotal rate;

(10) sum the standard general administrative support ratio, the program-related expense
ratio, and the absence and utilization factor ratio;

(11) divide the result of clause (9) by one minus the result of clause (10). This is the
total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount
in clause (11) by the number of service recipients, not to exceed three; and

(13) for night supervision provided in a shared manner, divide the total payment amount
in clause (11) by the number of service recipients, not to exceed two; and

(14) adjust the result of clauses (12) and (13) 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, 2023, or upon federal approval,
whichever occurs later. The commissioner of human services shall notify the revisor of
statutes when federal approval is obtained.

Sec. 50. Laws 2022, chapter 33, section 1, subdivision 10c, is amended to read:

Subd. 10c. Reporting and analysis of competitive workforce factor. (a) Beginning
February 1, 2024, 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:

(b) 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 10b;
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. This subdivision expires upon submission of the calendar year 2030 report.

**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. 51. Laws 2022, chapter 40, section 6, is amended to read:

Sec. 6. COMMISSIONER OF HUMAN SERVICES; TEMPORARY STAFFING POOL; APPROPRIATION.

(a) The commissioner of human services shall establish a temporary emergency staffing pool for congregate settings and for providers or recipients of home- and community-based services experiencing staffing crises. Vendor contracts may include retention bonuses, sign-on bonuses, and payment for hours on call. The commissioner may pay for necessary training, travel, and lodging expenses of the temporary staff. Contracts for temporary staffing executed under this section: (1) should minimize the recruitment away from providers’ current workforces; and (2) may not be executed with an individual until at least 30 days since the individual was last employed in Minnesota by one of the types of facilities, providers, or individuals listed in paragraph (g).

(b) Temporary staff, at the request of the commissioner, may be deployed to providers of home- and community-based services, individual recipients of home- and community-based services, and long-term care facilities and programs experiencing an emergency staffing crisis on or after the effective date of this section. Temporary staff must be provided at no cost to the provider, individual recipient, facility, or program receiving the temporary staff.

(c) Members of the temporary staffing pool under this section are not state employees.

(d) The commissioner must coordinate the activities under this section with any other impacted state agencies, to appropriately prioritize locations to deploy contracted temporary staff.

(e) The commissioner must give priority for deploying staff to providers, individual recipients, facilities, and programs with the most significant staffing crises and where, but for this assistance, residents or service recipients would be at significant risk of injury due to the need to transfer to another facility or a hospital for adequately staffed care.

(f) A provider, individual recipient, facility, or program may seek onetime assistance for setting or individual service recipient from the temporary staffing pool only after the provider, individual recipient, facility, or program has used all resources available to obtain temporary staff but is unable to meet the provider’s, individual’s, facility’s, or program’s temporary staffing needs. A provider, individual, facility, or program may apply for
temporary staff for up to 21 days. Applicants must submit a proposed plan for ensuring
resident safety at the end of that time period.

(g) Providers, individuals, facilities, and programs eligible to obtain temporary staff
from the temporary staffing pool include:

(1) nursing facilities;
(2) assisted living facilities;
(3) intermediate care facilities for persons with developmental disabilities;
(4) adult foster care or community residential settings, or integrated community supports
settings;
(5) licensed substance use disorder treatment facilities;
(6) unlicensed county-based substance use disorder treatment facilities;
(7) licensed facilities for adults with mental illness;
(8) licensed detoxification programs;
(9) licensed withdrawal management programs;
(10) licensed children's residential facilities;
(11) licensed child foster residence settings;
(12) unlicensed, Tribal-certified facilities that perform functions similar to the licensed
facilities listed in this paragraph;
(13) boarding care homes;
(14) board and lodging establishments serving people with disabilities or disabling
conditions;
(15) board and lodging establishments with special services;
(16) supervised living facilities;
(17) supportive housing;
(18) sober homes;
(19) community-based halfway houses for people exiting the correctional system;
(20) shelters serving people experiencing homelessness;
(21) drop-in centers for people experiencing homelessness;
(22) homeless outreach services for unsheltered individuals;
(23) shelters for people experiencing domestic violence; and
62.17 (24) temporary isolation spaces for people who test positive for COVID-19;
62.18 (25) individuals who use consumer-directed community supports;
62.19 (26) individuals who use the personal care assistance choice program;
62.20 (27) personal care assistance provider agencies;
62.21 (28) individuals who use the community first services and supports budget model;
62.22 (29) agency-providers of community first services and supports; and
62.23 (30) providers of individualized home supports.

62.24 (h) Notwithstanding Minnesota Statutes, chapter 16C, the commissioner may maintain,
62.25 extend, or renew contracts for temporary staffing entered into on or after September 1, 2020.
62.26 The commissioner may also enter into new contracts with eligible entities for temporary
62.27 staff deployed in the temporary staffing pool. The commissioner may use up to 6.5 percent
62.28 of this funding for the commissioner's costs related to administration of this program.

63.1 (i) The commissioner shall seek all allowable FEMA reimbursement for the costs of this
63.2 activity.

SEC. 12. LAWS 2022, CHAPTER 40, SECTION 7, AMENDMENT FROM
S4410-3, ARTICLE 18, SECTION 12, TO MATCH UES4410-2, ARTICLE 9, SECTION 28.

494.1 Sec. 12. Laws 2022, chapter 40, section 7, is amended to read:
494.2 Sec. 7. APPROPRIATION; TEMPORARY STAFFING POOL.
494.3 $1,029,000 $3,145,000 in fiscal year 2022 is appropriated from the general fund to the
494.4 commissioner of human services for the temporary staffing pool described in this act. This
494.5 is a onetime appropriation and is available until June 30, 2022.

494.6 EFFECTIVE DATE. This section is effective the day following final enactment.
494.7 Subdivision 1. Grant program established. The commissioner of human services shall
494.8 establish grants for behavioral health, housing, disability, and home and community-based
494.9 older adult providers to assist with recruiting and retaining direct support and frontline
494.10 workers.
494.11 Subd. 2. Definitions. (a) For purposes of this section, the following terms have the
494.12 meanings given:
494.13 (b) "Commissioner" means the commissioner of human services.
"Eligible employer" means an organization enrolled in a Minnesota health care program or providing housing services that is:

1. A provider of home and community-based services under Minnesota Statutes, chapter 245D;
2. An agency provider or financial management service provider under Minnesota Statutes, section 256B.85;
3. A home care provider licensed under Minnesota Statutes, sections 144A.43 to 144A.482;
4. A facility certified as an intermediate care facility for persons with developmental disabilities;
5. A provider of home care services as defined in Minnesota Statutes, section 256B.0651, subdivision 1, paragraph (d);
6. An agency as defined in Minnesota Statutes, section 256B.0949, subdivision 2;
7. A provider of mental health day treatment services for children or adults;
8. A provider of emergency services as defined in Minnesota Statutes, section 256E.36;
9. A provider of housing support as defined in Minnesota Statutes, chapter 256I;
10. A provider of housing stabilization services as defined in Minnesota Statutes, section 256I.051;
11. A provider of transitional housing programs as defined in Minnesota Statutes, section 256E.33;
12. A provider of substance use disorder services as defined in Minnesota Statutes, chapter 245G;
13. An eligible financial management service provider serving people through consumer-directed community supports under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S, and consumer support grants under Minnesota Statutes, section 256.476;
14. A provider of customized living services as defined in Minnesota Statutes, section 256S.02, subdivision 12, or
15. A provider who serves children with an emotional disorder or adults with mental illness under Minnesota Statutes, section 245I.011 or 256B.0671, providing services, including:
   a) Assertive community treatment;
   b) Intensive residential treatment services.
(iii) adult rehabilitative mental health services;
(iv) mobile crisis services;
(v) children's therapeutic services and supports;
(vi) children's residential services;
(vii) psychiatric residential treatment services;
(viii) outpatient mental health treatment provided by mental health professionals;
(ix) intensive mental health outpatient treatment services.

(d) "Eligible worker" means a worker who earns $30 per hour or less and has worked in an eligible profession for at least six months. Eligible workers may receive up to $5,000 annually in payments from the workforce incentive fund.

Subd. 3. Allowable uses of grant money. (a) Grantees must use money awarded to provide payments to eligible workers for the following purposes:

(1) retention and incentive payments;
(2) postsecondary loan and tuition payments;
(3) child care costs;
(4) transportation-related costs; and
(5) other costs associated with retaining and recruiting workers, as approved by the commissioner.

(b) The commissioner must develop a grant cycle distribution plan that allows for equitable distribution of funding among eligible employer types. The commissioner's determination of the grant awards and amounts is final and is not subject to appeal.

(c) The commissioner must make efforts to prioritize eligible employers owned by persons who are Black, Indigenous, and people of color and small- to mid-sized eligible employers.

Subd. 4. Attestation. As a condition of obtaining grant payments under this section, an eligible employer must attest and agree to the following:

(1) the employer is an eligible employer;
(2) the total number of eligible employees;
(3) the employer will distribute the entire value of the grant to eligible employees, as allowed under this section;  
(4) the employer will create and maintain records under subdivision 6;  
(5) the employer will not use the money appropriated under this section for any purpose other than the purposes permitted under this section; and  
(6) the entire value of any grant amounts must be distributed to eligible employees identified by the provider.

Subd. 5. Audits and recoupment. (a) The commissioner may perform an audit under this section up to six years after the grant is awarded to ensure:  
(1) the grantee used the money solely for the purposes stated in subdivision 3;  
(2) the grantee was truthful when making attestations under subdivision 5; and  
(3) the grantee complied with the conditions of receiving a grant under this section.

(b) If the commissioner determines that a grantee used awarded money for purposes not authorized under this section, the commissioner must treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner must recover any overpayment.

Subd. 6. Self-directed services workforce. Grants paid to eligible employees providing services within the covered programs defined in Minnesota Statutes, section 256B.0711, do not constitute a change in a term or condition for individual providers in covered programs and are not subject to the state's obligation to meet and negotiate under Minnesota Statutes, chapter 179A.

Subd. 7. Grants not to be considered income. (a) For the purposes of this subdivision, "subtraction" has the meaning given in Minnesota Statutes, section 290.0132, subdivision 1, paragraph (a), and the rules in that subdivision apply for this subdivision. The definitions in Minnesota Statutes, section 290.01, apply to this subdivision.

(b) The amount of grant awards received under this section is a subtraction.

(c) Grant awards under this section are excluded from income, as defined in Minnesota Statutes, sections 290.0674, subdivision 2a, and 290A.03, subdivision 3.

(d) Notwithstanding any law to the contrary, grant awards under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:  
(1) child care assistance programs under Minnesota Statutes, chapter 119B;  
(2) general assistance, Minnesota supplemental aid, and food support under Minnesota Statutes, chapter 256D;
(3) housing support under Minnesota Statutes, chapter 256I;
(4) Minnesota family investment program and diversionary work program under Minnesota Statutes, chapter 256J; and
(5) economic assistance programs under Minnesota Statutes, chapter 256P.

(e) The commissioner of human services must not consider grant awards under this section as income or assets under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under Minnesota Statutes, section 256B.057, subdivision 3, 3a, or 3b.

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

Sec. 30. DIRECT CARE SERVICE CORPS PILOT PROJECT.

Subd. 1. Establishment. HealthForce Minnesota at Winona State University must develop a pilot project establishing the Minnesota Direct Care Service Corps. The pilot program must utilize financial incentives to attract postsecondary students to work as personal care assistants or direct support professionals. HealthForce Minnesota must establish the financial incentives and minimum work requirements to be eligible for incentive payments.

The financial incentive must increase with each semester that the student participates in the Minnesota Direct Care Service Corps.

Subd. 2. Pilot sites. (a) Pilot sites must include one postsecondary institution in the seven-county metropolitan area and at least one postsecondary institution outside of the seven-county metropolitan area. If more than one postsecondary institution outside the metropolitan area is selected, one must be located in northern Minnesota and the other must be located in southern Minnesota.

(b) After satisfactorily completing the work requirements for a semester, the pilot site or its fiscal agent must pay students the financial incentive developed for the pilot project.

Subd. 3. Evaluation and report. (a) HealthForce Minnesota must contract with a third party to evaluate the pilot project's impact on health care costs, retention of personal care assistants, and patients' and providers' satisfaction of care. The evaluation must include the number of participants, the hours of care provided by participants, and the retention of participants from semester to semester.

(b) By January 4, 2024, HealthForce Minnesota must report the findings under paragraph (a) to the chairs and ranking members of the legislative committees with jurisdiction over human services policy and finance.
Sec. 31. DIRECTION TO COMMISSIONER OF HUMAN SERVICES:

LIFE-SHARING SERVICES.

Subdivision 1. Recommendations required. The commissioner of human services shall develop recommendations for establishing life sharing as a covered medical assistance waiver service.

Subd. 2. Definition. For the purposes of this section, “life sharing” means a relationship-based living arrangement between an adult with a disability and an individual or family in which they share their lives and experiences while the adult with a disability receives support from the individual or family using person-centered practices.

Subd. 3. Stakeholder engagement and consultation. (a) The commissioner must proactively solicit participation in the development of the life-sharing medical assistance service through a robust stakeholder engagement process that results in the inclusion of a racially, culturally, and geographically diverse group of interested stakeholders from each of the following groups:

1. Providers currently providing or interested in providing life-sharing services;
2. People with disabilities accessing or interested in accessing life-sharing services;
3. Disability advocacy organizations; and
4. Lead agencies.

(b) The commissioner must proactively seek input into and assistance with the development of recommendations for establishing the life-sharing service from interested stakeholders. (c) The commissioner must provide a method for the commissioner and interested stakeholders to cofacilitate public meetings. The first meeting must occur before January 31, 2023. All meetings must be accessible to all interested stakeholders, recorded, and posted online within one week of the meeting date.

Subd. 4. Required topics to be discussed during development of the recommendations. The commissioner and the interested stakeholders must discuss the following topics:

1. The distinction between life sharing and adult family foster care;
2. Successful life-sharing models used in other states;
3. Services and supports that could be included in a life-sharing service;
4. Potential barriers to providing or accessing life-sharing services;
5. Solutions to remove identified barriers to providing or accessing life-sharing services;
6. Disability advocacy organizations;
7. Lead agencies.

For the purposes of this section, “life sharing” means a relationship-based living arrangement between an adult with a disability and an individual or family in which they share their lives and experiences while the adult with a disability receives support from the individual or family using person-centered practices.

Subd. 2. Definition. For the purposes of this section, “life sharing” means a relationship-based living arrangement between an adult with a disability and an individual or family in which they share their lives and experiences while the adult with a disability receives support from the individual or family using person-centered practices.

Subd. 3. Stakeholder engagement and consultation. (a) The commissioner must proactively solicit participation in the development of the life-sharing medical assistance service through a robust stakeholder engagement process that results in the inclusion of a racially, culturally, and geographically diverse group of interested stakeholders from each of the following groups:

1. Providers currently providing or interested in providing life-sharing services;
2. People with disabilities accessing or interested in accessing life-sharing services;
3. Disability advocacy organizations; and
4. Lead agencies.

(b) The commissioner must proactively seek input into and assistance with the development of recommendations for establishing the life-sharing service from interested stakeholders.

(c) The commissioner must provide a method for the commissioner and interested stakeholders to cofacilitate public meetings. The first meeting must occur before January 31, 2023. All meetings must be accessible to all interested stakeholders, recorded, and posted online within one week of the meeting date.

Subd. 4. Required topics to be discussed during development of the recommendations. The commissioner and the interested stakeholders must discuss the following topics:

1. The distinction between life sharing and adult family foster care;
2. Successful life-sharing models used in other states;
3. Services and supports that could be included in a life-sharing service;
4. Potential barriers to providing or accessing life-sharing services;
5. Solutions to remove identified barriers to providing or accessing life-sharing services;
69.5 (6) potential medical assistance payment methodologies for life-sharing services;
69.6 (7) expanding awareness of the life-sharing model; and
69.7 (8) draft language for legislation necessary to define and implement life-sharing services.

Subd. 5. Report to the legislature. By December 31, 2023, 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 a report
summarizing the discussions between the commissioner and the interested stakeholders and
the commissioner's recommendations. The report must also include any draft legislation
necessary to define and implement life-sharing services.

Sec. 32. TASK FORCE ON DISABILITY SERVICES ACCESSIBILITY.
Subdivision 1. Establishment; purpose. The Task Force on Disability Services
Accessibility is established to evaluate the accessibility of current state and county disability
services and to develop and evaluate plans to address barriers to accessibility.

Subd. 2. Definitions. (a) For purposes of this section, the terms in this subdivision have
the meanings given:

(b) "Accessible" means that a service or program is easily navigated without
accommodation or assistance, or, if reasonable accommodations are needed to navigate a
service or program, accommodations are chosen by the participant and effectively
implemented without excessive burden to the participant. Accessible communication means
communication that a person understands, with appropriate accommodations as needed:
including language or other interpretation.

(g) "Commissioner" means the commissioner of the Department of Human Services;

(h) "Disability services" means services provided through Medicaid, including personal
care assistance, home care, other home and community-based services, waivers, and other
home and community-based disability services provided through lead agencies;

(e) "Lead agency" means a county, Tribe, or health plan under contract with the
commissioner to administer disability services;

(f) "Task force" means the Task Force on Disability Services Accessibility;

Subd. 3. Membership. (a) The task force consists of 24 members as follows:

(1) the commissioner of human services or a designee;

(2) one member appointed by the Minnesota Council on Disability;

(3) the ombudsman for mental health and developmental disabilities or a designee;
(4) two representatives of counties or Tribal agencies appointed by the commissioner of human services;

(5) one member appointed by the Minnesota Association of County Social Service Administrators;

(6) one member appointed by the Minnesota Disability Law Center;

(7) one member appointed by the Arc of Minnesota;

(8) one member appointed by the Autism Society of Minnesota;

(9) one member appointed by the Service Employees International Union;

(10) five members appointed by the commissioner of human services who are people with disabilities, including at least one individual who has been denied services from the state or county and two individuals who use different types of disability services;

(11) three members appointed by the commissioner of human services who are parents of children with disabilities who use different types of disability services;

(12) one member appointed by the Association of Residential Resources in Minnesota;

(13) one member appointed by the Minnesota First Provider Alliance;

(14) one member appointed by the Minnesota Commission of the Deaf, DeafBlind and Hard of Hearing;

(15) one member appointed by the Minnesota Organization for Habilitation and Rehabilitation; and

(16) two members appointed by the commissioner of human services who are direct service professionals.

(b) To the extent possible, membership on the task force under paragraph (a) shall reflect geographic parity throughout the state and representation from Black and Indigenous communities and communities of color.

(c) The membership terms, compensation, expense reimbursement, and removal and filling of vacancies of task force members are as provided in section 15.059.

Subd. 4. Appointment deadline; first meeting; chair. Appointing authorities must complete member selections by August 1, 2022. The commissioner shall convene the first meeting of the task force by September 15, 2022. The task force shall select a chair from among its members at its first meeting. The chair shall convene all subsequent meetings.

Subd. 5. Goals. The goals of the task force include:

(1) developing plans and executing methods to investigate accessibility of disability services, including consideration of the following inquiries:
(ii) how accessible is the program or service without assistance or accommodation, including what accessibility options exist, how the accessibility options are communicated, what communication options are available, what trainings are provided to ensure accessibility options are implemented, and available processes for filing consumer accessibility complaints and correcting administrative errors;

(iii) the impact of accessibility barriers on individuals' access to services, including information about service denials or reductions due to accessibility issues, and aggregate information about reductions and denials related to disability or support need types and reasons for reductions and denials; and

(iii) what areas of discrepancy exist between declared state and county disability policy goals and enumerated state and federal laws and the experiences of people who have disabilities in accessing services;

(2) identifying areas of inaccessibility creating inefficiencies that financially impact the state and counties, including:

(i) the number and cost of appeals, including the number of appeals of service denials or reductions that are ultimately overturned;

(ii) the cost of crisis intervention because of service failure; and

(iii) the cost of redoing work that was not done correctly initially; and

(3) assessing the efficacy of possible solutions.

Subd. 6. Duties; plan and recommendations. (a) The task force shall work with the commissioner to identify investigative areas and to develop a plan to conduct an accessibility assessment of disability services provided by lead agencies and the Department of Human Services. The assessment shall:

(1) identify accessibility barriers and impediments created by current policies, procedures, and implementation;

(2) identify and analyze accessibility barrier and impediment impacts on different demographics;

(3) gather information from:

(i) the Department of Human Services;

(ii) relevant state agencies and staff;

(iii) counties and relevant staff;

(iv) people who use disability services;

(v) disability advocates; and
(vi) family members and other support people for individuals who use disability services;

(4) identify barriers to accessibility improvements in state and county services; and

(5) identify benefits to the state and counties in improving accessibility of disability services.

(b) For the purposes of the assessment, disability services include:

(1) access to services;

(2) explanation of services;

(3) maintenance of services;

(4) application of services;

(5) services participant understanding of rights and responsibilities;

(6) communication regarding services;

(7) requests for accommodations;

(8) processes for filing complaints or grievances; and

(9) processes for appealing decisions denying or reducing services or eligibility.

(c) The task force shall collaborate with stakeholders, counties, and state agencies to develop recommendations from the findings of the assessment and to create sustainable and accessible changes to county and state services to improve outcomes for people with disabilities. The recommendations shall include:

(1) recommendations to eliminate barriers identified in the assessment, including but not limited to recommendations for state legislative action, state policy action, and lead agency changes;

(2) benchmarks for measuring annual progress toward increasing accessibility in county and state disability services to be annually evaluated by the commissioner and the Minnesota Council on Disability;

(3) a proposed method for monitoring and tracking accessibility in disability services;

(4) proposed initiatives, training, and services designed to improve accessibility and effectiveness of county and state disability services, including recommendations for needed electronic or other communication changes in order to facilitate accessible communication for participants; and

(5) recommendations for sustainable financial support and resources for improving accessibility.
(d) The task force shall oversee preparation of a report outlining the findings from the
accessibility assessment in paragraph (a) and the recommendations developed pursuant to
paragraph (b) according to subdivision 7.

Subd. 7. Report. By September 30, 2023, the task force shall submit a report with
recommendations to the chairs and ranking minority members of the committees and divisions
in the senate and house of representatives with jurisdiction over health and human services.
This report must comply with subdivision 6, paragraph (d), include any changes to statutes,
laws, or rules required to implement the recommendations of the task force, and include a
recommendation concerning continuing the task force beyond its scheduled expiration.

Subd. 8. Administrative support. The commissioner of human services shall provide
meeting space and administrative services to the task force.

Sec. 33. DIRECTION TO COMMISSIONER; SHARED SERVICES.
(a) By December 1, 2022, the commissioner of human services shall seek any necessary
changes to home and community-based services waiver plans regarding sharing services in
order to:
(1) permit shared services for more services, including chore, homemaker, and night
supervision;
(2) permit shared services for some services for higher ratios, including individualized
home supports without training, individualized home supports with family training for a ratio of one staff person to three
recipients;
(3) ensure that individuals who are seeking to share services permitted under the waiver
plans in an own-home setting are not required to live in a licensed setting in order to share
services so long as all other requirements are met; and
(4) issue guidance for shared services, including:
(i) informed choice for all individuals sharing the services;
(ii) guidance for when multiple shared services by different providers occur in one home
and how lead agencies and individuals shall determine that shared service is appropriate to
meet the needs, health, and safety of each individual for whom the lead agency provides
case management or care coordination; and
(iii) guidance clarifying that an individual's decision to share services does not reduce
determination of the individual's overall or assessed needs for services.
(b) The commissioner shall develop or provide guidance outlining:

Sec. 58. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; SHARED SERVICES.
(a) By December 1, 2022, the commissioner of human services shall seek any necessary
changes to home and community-based services waiver plans regarding sharing services in
order to:
(1) permit shared services for more services, including chore, homemaker, and night
supervision;
(2) permit shared services for some services for higher ratios, including individualized
home supports without training, individualized home supports with training, and
individualized home supports with family training for a ratio of one staff person to three
recipients;
(3) ensure that individuals who are seeking to share services permitted under the waiver
plans in an own-home setting are not required to live in a licensed setting in order to share
services so long as all other requirements are met; and
(4) issue guidance for shared services, including:
(i) informed choice for all individuals sharing the services;
(ii) guidance for when multiple shared services by different providers occur in one home
and how lead agencies and individuals shall determine that shared service is appropriate to
meet the needs, health, and safety of each individual for whom the lead agency provides
case management or care coordination; and
(iii) guidance clarifying that an individual's decision to share services does not reduce
determination of the individual's overall or assessed needs for services.
(b) The commissioner shall develop or provide guidance outlining:
(1) instructions for shared services support planning;
(2) person-centered approaches and informed choice in shared services support planning;
(3) required contents of shared services agreements.

The commissioner of human services shall increase by 2.8 percent the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed two times the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared service have been met.

Sec. 52. PERSONAL CARE ASSISTANCE ENHANCED RATE FOR PERSONS WHO USE CONSUMER-DIRECTED COMMUNITY SUPPORTS.

The commissioner of human services shall increase the annual budgets for participants who use consumer-directed community supports under Minnesota Statutes, sections 256B.091, subdivision 5, clause (17); 256B.092, subdivision 1b, paragraph (a), clause (4); 256B.49, subdivision 16, paragraph (c); and chapter 256S, by 43 percent for participants who are determined by assessment to be eligible for ten or more hours of personal care assistance services or community first services and supports per day when the participant uses direct support services provided by a worker employed by the participant who has completed training identified in Minnesota Statutes, section 256B.0659, subdivision 11, paragraph (d), or 256B.85, subdivision 16, paragraph (e).

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. 53. RATE INCREASE FOR CERTAIN HOME CARE SERVICES.

Subdivision 1. Rate increases. (a) Effective January 1, 2023, or upon federal approval, whichever is later, the commissioner of human services shall increase payment rates for home health aide visits by 14 percent from the rates in effect on December 31, 2022. The commissioner must apply the annual rate increases under Minnesota Statutes, section 256B.0653, subdivision 8, to the rates resulting from the application of the rate increases under this paragraph;
63.24 (b) Effective January 1, 2023, or upon federal approval, whichever is later, the commissioner shall increase payment rates for respiratory therapy under Minnesota Rules, part 9505.0295, subpart 2, item E, and for home health services and home care nursing services under Minnesota Statutes, section 256B.0651, subdivision 2, clauses (1) to (3), except home health aide visits, by 38.8 percent from the rates in effect on December 31, 2022. The commissioner must apply the annual rate increases under Minnesota Statutes, sections 256B.0653, subdivision 8, and 256B.0654, subdivision 5, to the rates resulting from the application of the rate increase under this paragraph.

63.32 Subd. 2. Spending requirements. (a) At least 80 percent of the marginal increase in revenue for home care services resulting from implementation of the rate increases under this section for services rendered on or after the day of implementation of the increase must be used to increase compensation-related costs for employees directly employed by the provider to provide the services.

64.1 (b) For the purposes of this subdivision, compensation-related costs include:

64.2 (1) wages and salaries;

64.3 (2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

64.4 (3) the employer's paid share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

64.5 (4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to implementation of the rate increases.

64.6 (c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider, or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

64.7 (d) A provider agency or individual provider that receives additional revenue subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of the new rate methodology or any rate adjustment subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee has not received the compensation-related increase described in the plan.

PAGE R83-A9 REVISOR FULL-TEXT SIDE-BY-SIDE
Sec. 54. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;
ADDITIONAL DWRS RATE INCREASES.

Subdivision 1. Additional rate increases. (a) In addition to the rate increases described in the amendments contained in this act to Minnesota Statutes, section 256B.4914, the commissioner shall further adjust the rates as described in paragraphs (b) to (f) until the net increase in the rates established under Minnesota Statutes, section 256B.4914, as amended in this act, and under this section are equivalent to a three-year appropriation of $253,001,000 for fiscal years 2023, 2024, and 2025. The commissioner shall apply the rate changes in this section after applying other changes contained in this act. The commissioner shall apply the rate changes in this section in the order presented in the following paragraphs. If the three-year appropriation target is reached after applying the provisions of a paragraph, the commissioner shall not apply the provisions in the remaining paragraphs.

(b) Notwithstanding Minnesota Statutes, section 256B.4914, subdivision 5, paragraph (b), clause (2), as added by amendment in this act, on January 1, 2023, the commissioner shall adjust the data used to update the base wage index by using up to the most recently available wage data by SOC code from the Bureau of Labor Statistics. If the estimated cost of fully implementing the rate adjustment in this paragraph exceeds the three-year appropriation target, the commissioner shall proportionately reduce the estimated change to the wage index to reach the target.

(c) Notwithstanding Minnesota Statutes, section 256B.4914, subdivision 5b, clause (2), as added by amendment in this act, on January 1, 2023, the commissioner shall adjust the data used to update the client and programming support, transportation, and program facility cost component values by using up to the most recently available data. If the estimated cost of fully implementing the rate adjustment in this paragraph exceeds the three-year appropriation target, the commissioner shall proportionately reduce the estimated change to component values to reach the target.

(d) Notwithstanding the provision in Minnesota Statutes, section 256B.4914, subdivision 5f, paragraph (a), as added by amendment in this act, requiring a biennial update of the competitive workforce factor, on January 1, 2024, the commissioner shall update the competitive workforce factor. If the estimated cost of fully implementing the rate adjustment in this paragraph exceeds the three-year appropriation target, the commissioner shall cap the increase in the competitive workforce factor to reach the target.

(e) Notwithstanding the provision in Minnesota Statutes, section 256B.4914, subdivision 5, paragraph (b), as amended in this act, on January 1, 2024, the commissioner shall update the base wage index in Minnesota Statutes, section 256B.4914, subdivision 5a, based on the most recently available wage data by SOC from the Bureau of Labor Statistics. If the estimated cost of fully implementing the rate adjustment in this paragraph exceeds the three-year appropriation target, the commissioner shall proportionately reduce the estimated change to component values to reach the target.
(f) Notwithstanding the provision in Minnesota Statutes, section 256B.4914, subdivision 5b, as amended in this act, on January 1, 2024, the commissioner shall update the client and programming support, transportation, and program facility cost component values based on the most recently available wage data by SOC from the Bureau of Labor Statistics. If the estimated cost of fully implementing the rate adjustment in this paragraph exceeds the three-year appropriation target, the commissioner shall proportionately reduce the estimated change to component values to reach the target.

Subd. 2. Spending requirements. A program or provider that receives a rate increase under this section is subject to the requirements of Minnesota Statutes, section 256B.4914, subdivision 5e.

Sec. 55. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; APPLICATION OF ICF/DD RATE INCREASES.

The commissioner of human services shall apply the rate increases under Minnesota Statutes, section 256B.5012, subdivisions 19 and 20, as follows:

(1) apply Minnesota Statutes, section 256B.5012, subdivision 19; and
(2) apply any required rate increase as required under Minnesota Statutes, section 256B.5012, subdivision 20, to the results of clause (1).

Sec. 56. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; BUDGET EXCEPTIONS FOR COMMUNITY RESIDENTIAL SETTINGS.

The commissioner of human services must take steps to inform individuals, families, and lead agencies of the amendments to Minnesota Statutes, section 256B.4911, subdivision 4, and widely disseminate easily understood instructions for quickly applying for a budget exception under that 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. 37. DIRECTION TO COMMISSIONER; INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DISABILITIES RATE STUDY.

The commissioner of human services shall study medical assistance payment rates for intermediate care facilities for persons with disabilities under Minnesota Statutes, sections 256B.5011 to 256B.5015; make recommendations on establishing a new payment rate methodology for these facilities; and submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance by February 15, 2023, that includes the recommendations and any draft legislation necessary to implement the recommendations.

Sec. 60. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; FINANCIAL MANAGEMENT SERVICES PROVIDERS.

The commissioner of human services shall accept on a rolling basis proposals submitted in response to "Request for Proposals for Qualified Grantees to Provide Vendor Fiscal/Employer Agent Financial Management Services," published on May 2, 2016. Responders must comply with all proposal instructions and requirements as set forth in the request for proposals except the submission deadlines. The commissioner shall evaluate all responsive proposals submitted under this section regardless of the date on which the proposal is submitted. The commissioner shall conduct phase I and phase II evaluations using the same procedures and evaluation standards set forth in the request for proposals. The commissioner shall contact responders who submit substantially complete proposals to provide further or missing information or to clarify the responder's proposal. The commissioner shall select all responders that successfully move on to phase III evaluation. For all proposals that move on to phase III evaluation, the commissioner shall not exercise the commissioner's right to reject any or all proposals. The commissioner shall not compare proposals that successfully move on to phase III evaluation. The commissioner shall not reject a proposal that successfully moved on to phase III evaluation after determining that another proposal is more advantageous to the state. This section expires upon publication of a new request for proposals related to financial management services providers.

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