

SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 92

(SENATE AUTHORS: ABELER and Hoffman)

DATE	D-PG	OFFICIAL STATUS
01/14/2019	74	Introduction and first reading
		Referred to Human Services Reform Finance and Policy
04/11/2019		Comm report: To pass as amended and re-refer to Finance
		Rule 12.10: report of votes in committee

1.1 A bill for an act

1.2 relating to state government; establishing a portion of the health and human services

1.3 budget; modifying provisions governing program integrity, children and family

1.4 services, chemical and mental health, continuing care for older adults, disability

1.5 services, direct care and treatment, operations, and health care; modifying penalties;

1.6 establishing asset limits; establishing electronic visit verification system; eliminating

1.7 TEFRA fees; repealing MFIP child care assistance program and basic sliding fee

1.8 child care assistance program; directing the commissioner of human services to

1.9 propose a redesigned child care assistance program; directing closure of a MSOCS

1.10 residential facility; repealing statutes relating to the state-operated services account;

1.11 establishing a background study set-aside for individuals working in the substance

1.12 use disorder treatment field; requiring reports; making technical changes;

1.13 appropriating money; amending Minnesota Statutes 2018, sections 13.69,

1.14 subdivision 1; 13.851, by adding a subdivision; 15C.02; 119B.09, subdivisions 1,

1.15 4, 7, 9, 9a; 119B.125, subdivision 6, by adding subdivisions; 119B.13, subdivisions

1.16 6, 7; 144.057, subdivision 3; 144A.073, by adding a subdivision; 144A.479, by

1.17 adding a subdivision; 245.095; 245.4889, subdivision 1; 245A.03, subdivision 7;

1.18 245A.04, subdivision 7, by adding a subdivision; 245A.065; 245A.11, subdivision

1.19 2a; 245C.02, by adding a subdivision; 245C.22, subdivisions 4, 5; 245D.03,

1.20 subdivision 1; 245D.071, subdivision 5; 245D.09, subdivisions 5, 5a; 245D.091,

1.21 subdivisions 2, 3, 4; 245E.02, by adding a subdivision; 246.54, by adding a

1.22 subdivision; 252.27, subdivision 2a; 252.275, subdivision 3; 254A.03, subdivision

1.23 3; 254A.19, by adding a subdivision; 254B.02, subdivision 1; 254B.03, subdivisions

1.24 2, 4; 254B.04, subdivision 1; 254B.05, subdivision 1a; 254B.06, subdivisions 1,

1.25 2; 256.9365; 256.98, subdivisions 1, 8; 256.987, subdivisions 1, 2; 256B.02,

1.26 subdivision 7, by adding a subdivision; 256B.04, subdivision 21; 256B.056,

1.27 subdivisions 3, 4, 5c, 7a; 256B.0625, subdivisions 17, 18d, 18h, 19a, 24, 43, by

1.28 adding subdivisions; 256B.064, subdivisions 1b, 2, by adding a subdivision;

1.29 256B.0651, subdivision 17; 256B.0652, subdivision 6; 256B.0658; 256B.0659,

1.30 subdivisions 3, 3a, 11, 12, 13, 14, 19, 21, 24, 28, by adding a subdivision;

1.31 256B.0757, subdivisions 1, 2, 4, by adding subdivisions; 256B.0911, subdivisions

1.32 1a, 3a, 3f, 5, by adding a subdivision; 256B.0915, subdivisions 6, 10, by adding

1.33 a subdivision; 256B.092, subdivision 1b, by adding a subdivision; 256B.0921;

1.34 256B.14, subdivision 2; 256B.27, subdivision 3; 256B.49, subdivisions 13, 14, by

1.35 adding a subdivision; 256B.4912, by adding subdivisions; 256B.4914, subdivisions

1.36 2, 3, 5, 10, 10a; 256B.493, subdivision 1; 256B.5013, subdivisions 1, 6; 256B.5014;

1.37 256B.5015, subdivision 2; 256B.85, subdivisions 3, 8, 10; 256C.23, by adding a

1.38 subdivision; 256C.261; 256D.024, subdivision 3; 256D.0515; 256D.0516,

2.1 subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2b, 2f, by adding
 2.2 subdivisions; 256I.05, subdivision 1r; 256I.06, subdivision 8; 256J.08, subdivision
 2.3 47; 256J.21, subdivision 2; 256J.26, subdivision 3; 256L.01, subdivision 5;
 2.4 256M.41, subdivision 3, by adding a subdivision; 256P.04, subdivision 4; 256P.06,
 2.5 subdivision 3; 256R.25; 518A.32, subdivision 3; 518A.51; 641.15, subdivision
 2.6 3a; Laws 2017, First Special Session chapter 6, article 1, sections 44; 45; article
 2.7 3, section 49; article 18, section 7; proposing coding for new law in Minnesota
 2.8 Statutes, chapters 245A; 256; 256B; 256D; 256J; 256R; 260C; 268A; repealing
 2.9 Minnesota Statutes 2018, sections 16A.724, subdivision 2; 119B.011, subdivisions
 2.10 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10a, 11, 12, 13, 13a, 14, 15, 16, 17, 18, 19, 19a, 19b,
 2.11 20, 20a, 21, 22; 119B.02; 119B.025, subdivisions 1, 2, 3, 4; 119B.03, subdivisions
 2.12 1, 2, 3, 4, 5, 6, 6a, 6b, 8, 9, 10; 119B.035; 119B.04; 119B.05, subdivisions 1, 4,
 2.13 5; 119B.06, subdivisions 1, 2, 3; 119B.08, subdivisions 1, 2, 3; 119B.09,
 2.14 subdivisions 1, 3, 4, 4a, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13; 119B.095; 119B.097;
 2.15 119B.10, subdivisions 1, 2, 3; 119B.105; 119B.11, subdivisions 1, 2a, 3, 4;
 2.16 119B.12, subdivisions 1, 2; 119B.125; 119B.13, subdivisions 1, 1a, 3, 3a, 3b, 3c,
 2.17 4, 5, 6, 7; 119B.14; 119B.15; 119B.16; 245G.11, subdivisions 1, 4, 7; 246.18,
 2.18 subdivisions 8, 9; 254B.03, subdivision 4a; 256B.0705; 256I.05, subdivision 3;
 2.19 256R.53, subdivision 2; Laws 2017, First Special Session chapter 6, article 7,
 2.20 section 34; Minnesota Rules, parts 3400.0010; 3400.0020, subparts 1, 4, 5, 8, 9a,
 2.21 10a, 12, 17a, 18, 18a, 20, 24, 25, 26, 28, 29a, 31b, 32b, 33, 34a, 35, 37, 38, 38a,
 2.22 38b, 39, 40, 40a, 44; 3400.0030; 3400.0035; 3400.0040, subparts 1, 3, 4, 5, 5a,
 2.23 6a, 6b, 6c, 7, 8, 9, 10, 11, 12, 13, 14, 15, 15a, 17, 18; 3400.0060, subparts 2, 4, 5,
 2.24 6, 6a, 7, 8, 9, 10; 3400.0080, subparts 1, 1a, 1b, 8; 3400.0090, subparts 1, 2, 3, 4;
 2.25 3400.0100, subparts 2a, 2b, 2c, 5; 3400.0110, subparts 1, 1a, 2, 2a, 3, 4a, 7, 8, 9,
 2.26 10, 11; 3400.0120, subparts 1, 1a, 2, 2a, 3, 5; 3400.0130, subparts 1, 1a, 2, 3, 3a,
 2.27 3b, 5, 5a, 7; 3400.0140, subparts 1, 2, 4, 5, 6, 7, 8, 9, 9a, 10, 14; 3400.0150;
 2.28 3400.0170, subparts 1, 3, 4, 6a, 7, 8, 9, 10, 11; 3400.0180; 3400.0183, subparts 1,
 2.29 2, 5; 3400.0185; 3400.0187, subparts 1, 2, 3, 4, 6; 3400.0200; 3400.0220;
 2.30 3400.0230, subpart 3; 3400.0235, subparts 1, 2, 3, 4, 5, 6; 9530.6800; 9530.6810.

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

2.32 **ARTICLE 1**

2.33 **PROGRAM INTEGRITY**

2.34 Section 1. Minnesota Statutes 2018, section 15C.02, is amended to read:

2.35 **15C.02 LIABILITY FOR CERTAIN ACTS.**

2.36 (a) A person who commits any act described in clauses (1) to (7) is liable to the state or
 2.37 the political subdivision for a civil penalty of ~~not less than \$5,500 and not more than \$11,000~~
 2.38 per false or fraudulent claim in the amounts set forth in the federal False Claims Act, United
 2.39 States Code, title 31, section 3729, and as modified by the federal Civil Penalties Inflation
 2.40 Adjustment Act Improvements Act of 2015, plus three times the amount of damages that
 2.41 the state or the political subdivision sustains because of the act of that person, except as
 2.42 otherwise provided in paragraph (b):

2.43 (1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment
 2.44 or approval;

3.1 (2) knowingly makes or uses, or causes to be made or used, a false record or statement
3.2 material to a false or fraudulent claim;

3.3 (3) knowingly conspires to commit a violation of clause (1), (2), (4), (5), (6), or (7);

3.4 (4) has possession, custody, or control of property or money used, or to be used, by the
3.5 state or a political subdivision and knowingly delivers or causes to be delivered less than
3.6 all of that money or property;

3.7 (5) is authorized to make or deliver a document certifying receipt for money or property
3.8 used, or to be used, by the state or a political subdivision and, intending to defraud the state
3.9 or a political subdivision, makes or delivers the receipt without completely knowing that
3.10 the information on the receipt is true;

3.11 (6) knowingly buys, or receives as a pledge of an obligation or debt, public property
3.12 from an officer or employee of the state or a political subdivision who lawfully may not
3.13 sell or pledge the property; or

3.14 (7) knowingly makes or uses, or causes to be made or used, a false record or statement
3.15 material to an obligation to pay or transmit money or property to the state or a political
3.16 subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an
3.17 obligation to pay or transmit money or property to the state or a political subdivision.

3.18 (b) Notwithstanding paragraph (a), the court may assess not less than two times the
3.19 amount of damages that the state or the political subdivision sustains because of the act of
3.20 the person if:

3.21 (1) the person committing a violation under paragraph (a) furnished an officer or
3.22 employee of the state or the political subdivision responsible for investigating the false or
3.23 fraudulent claim violation with all information known to the person about the violation
3.24 within 30 days after the date on which the person first obtained the information;

3.25 (2) the person fully cooperated with any investigation by the state or the political
3.26 subdivision of the violation; and

3.27 (3) at the time the person furnished the state or the political subdivision with information
3.28 about the violation, no criminal prosecution, civil action, or administrative action had been
3.29 commenced under this chapter with respect to the violation and the person did not have
3.30 actual knowledge of the existence of an investigation into the violation.

3.31 (c) A person violating this section is also liable to the state or the political subdivision
3.32 for the costs of a civil action brought to recover any penalty or damages.

4.1 (d) A person is not liable under this section for mere negligence, inadvertence, or mistake
4.2 with respect to activities involving a false or fraudulent claim.

4.3 Sec. 2. Minnesota Statutes 2018, section 119B.09, subdivision 1, is amended to read:

4.4 Subdivision 1. **General eligibility requirements.** (a) Child care services must be
4.5 available to families with financial resources, excluding vehicles, of less than \$100,000,
4.6 who need child care to find or keep employment or to obtain the training or education
4.7 necessary to find employment and who:

4.8 (1) have household income less than or equal to 67 percent of the state median income,
4.9 adjusted for family size, at application and redetermination, and meet the requirements of
4.10 section 119B.05; receive MFIP assistance; and are participating in employment and training
4.11 services under chapter 256J; or

4.12 (2) have household income less than or equal to 47 percent of the state median income,
4.13 adjusted for family size, at application and less than or equal to 67 percent of the state
4.14 median income, adjusted for family size, at redetermination.

4.15 (b) Child care services must be made available as in-kind services.

4.16 (c) All applicants for child care assistance and families currently receiving child care
4.17 assistance must be assisted and required to cooperate in establishment of paternity and
4.18 enforcement of child support obligations for all children in the family at application and
4.19 redetermination as a condition of program eligibility. For purposes of this section, a family
4.20 is considered to meet the requirement for cooperation when the family complies with the
4.21 requirements of section 256.741.

4.22 (d) All applicants for child care assistance and families currently receiving child care
4.23 assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition
4.24 of eligibility. The co-payment fee may include additional recoupment fees due to a child
4.25 care assistance program overpayment.

4.26 Sec. 3. Minnesota Statutes 2018, section 119B.09, subdivision 4, is amended to read:

4.27 Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant
4.28 family is the current monthly income of the family multiplied by 12 or the income for the
4.29 12-month period immediately preceding the date of application, or income calculated by
4.30 the method which provides the most accurate assessment of income available to the family.

4.31 (b) Self-employment income must be calculated based on gross receipts less operating
4.32 expenses authorized by the Internal Revenue Service.

5.1 (c) Income changes are processed under section 119B.025, subdivision 4. Included lump
 5.2 sums counted as income under section 256P.06, subdivision 3, must be annualized over 12
 5.3 months. Income includes all deposits into accounts owned or controlled by the applicant,
 5.4 including amounts spent on personal expenses including rent, mortgage, automobile-related
 5.5 expenses, utilities, and food and amounts received as salary or draws from business accounts.
 5.6 Income does not include a deposit specifically identified by the applicant as a loan or gift,
 5.7 for which the applicant provides the source, date, amount, and repayment terms. Income
 5.8 and assets must be verified with documentary evidence. If the applicant does not have
 5.9 sufficient evidence of income or assets, verification must be obtained from the source of
 5.10 the income or assets.

5.11 Sec. 4. Minnesota Statutes 2018, section 119B.09, subdivision 7, is amended to read:

5.12 Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child care
 5.13 assistance under this chapter is the later of the date the application was received by the
 5.14 county; the beginning date of employment, education, or training; the date the infant is born
 5.15 for applicants to the at-home infant care program; or the date a determination has been made
 5.16 that the applicant is a participant in employment and training services under Minnesota
 5.17 Rules, part 3400.0080, or chapter 256J.

5.18 (b) Payment ceases for a family under the at-home infant child care program when a
 5.19 family has used a total of 12 months of assistance as specified under section 119B.035.
 5.20 Payment of child care assistance for employed persons on MFIP is effective the date of
 5.21 employment or the date of MFIP eligibility, whichever is later. Payment of child care
 5.22 assistance for MFIP or DWP participants in employment and training services is effective
 5.23 the date of commencement of the services or the date of MFIP or DWP eligibility, whichever
 5.24 is later. Payment of child care assistance for transition year child care must be made
 5.25 retroactive to the date of eligibility for transition year child care.

5.26 (c) Notwithstanding paragraph (b), payment of child care assistance for participants
 5.27 eligible under section 119B.05 may only be made retroactive for a maximum of ~~six~~ zero
 5.28 months from the date of application for child care assistance.

5.29 **EFFECTIVE DATE.** This section is effective for applications processed on or after
 5.30 July 1, 2019.

5.31 Sec. 5. Minnesota Statutes 2018, section 119B.09, subdivision 9, is amended to read:

5.32 Subd. 9. **Licensed and legal nonlicensed family child care providers; assistance.** This
 5.33 subdivision applies to any provider providing care in a setting other than a licensed or

6.1 license-exempt child care center. Licensed and legal nonlicensed family child care providers
 6.2 and their employees are not eligible to receive child care assistance subsidies under this
 6.3 chapter for their own children or children in their family during the hours they are providing
 6.4 child care or being paid to provide child care. Child care providers and their employees are
 6.5 eligible to receive child care assistance subsidies for their children when they are engaged
 6.6 in other activities that meet the requirements of this chapter and for which child care
 6.7 assistance can be paid. The hours for which the provider or their employee receives a child
 6.8 care subsidy for their own children must not overlap with the hours the provider provides
 6.9 child care services.

6.10 Sec. 6. Minnesota Statutes 2018, section 119B.09, subdivision 9a, is amended to read:

6.11 Subd. 9a. **Child care centers authorizations; assistance dependents of employees**
 6.12 **and controlling individuals.** (a) A licensed or license-exempt child care center ~~may~~ must
 6.13 not receive authorizations for ~~25 or fewer children~~ more than seven children who are
 6.14 dependents of the center's employees or controlling individuals. ~~If a child care center is~~
 6.15 ~~authorized for more than 25 children who are dependents of center employees, the county~~
 6.16 ~~cannot authorize additional dependents of an employee until the number of children falls~~
 6.17 ~~below 25.~~

6.18 ~~(b) Funds paid to providers during the period of time when a center is authorized for~~
 6.19 ~~more than 25 children who are dependents of center employees must not be treated as~~
 6.20 ~~overpayments under section 119B.11, subdivision 2a, due to noncompliance with this~~
 6.21 ~~subdivision.~~

6.22 ~~(e)~~ (b) Nothing in this subdivision precludes the commissioner from conducting fraud
 6.23 investigations relating to child care assistance, imposing sanctions, and obtaining monetary
 6.24 recovery as otherwise provided by law.

6.25 Sec. 7. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

6.26 Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers
 6.27 receiving child care assistance payments must keep accurate and legible daily attendance
 6.28 records at the site where services are delivered for children receiving child care assistance
 6.29 and must make those records available immediately to the county or the commissioner upon
 6.30 request. The attendance records must be completed daily and include the date, the first and
 6.31 last name of each child in attendance, and the times when each child is dropped off and
 6.32 picked up. To the extent possible, the times that the child was dropped off to and picked up
 6.33 from the child care provider must be entered by the person dropping off or picking up the

7.1 child. The daily attendance records must be retained at the site where services are delivered
7.2 for six years after the date of service.

7.3 (b) Records that are not produced immediately under paragraph (a), unless a delay is
7.4 agreed upon by the commissioner and provider, shall not be valid for purposes of establishing
7.5 a child's attendance and shall result in an overpayment under paragraph (d).

7.6 (c) A county or the commissioner may deny or revoke a provider's authorization as a
7.7 child care provider to any applicant, rescind authorization of any provider, to receive child
7.8 care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a
7.9 fraud disqualification under section 256.98, take an action against the provider under chapter
7.10 245E, or establish an attendance record overpayment claim in the system under paragraph
7.11 (d) against a current or former provider, when the county or the commissioner knows or
7.12 has reason to believe that the provider has not complied with the record-keeping requirement
7.13 in this subdivision. A provider's failure to produce attendance records as requested on more
7.14 than one occasion constitutes grounds for disqualification as a provider.

7.15 (d) To calculate an attendance record overpayment under this subdivision, the
7.16 commissioner or county agency subtracts the maximum daily rate from the total amount
7.17 paid to a provider for each day that a child's attendance record is missing, unavailable,
7.18 incomplete, illegible, inaccurate, or otherwise inadequate.

7.19 (e) The commissioner shall develop criteria to direct a county when the county must
7.20 establish an attendance overpayment under this subdivision.

7.21 Sec. 8. Minnesota Statutes 2018, section 119B.125, is amended by adding a subdivision
7.22 to read:

7.23 Subd. 10. **Proof of surety bond coverage.** All licensed child care centers authorized
7.24 for reimbursement under this chapter that received child care assistance program revenue
7.25 equal to or greater than \$250,000 in the previous calendar year must provide to the
7.26 commissioner at least once per year proof of surety bond coverage of \$100,000 in a format
7.27 determined by the commissioner. The surety bond must be in a form approved by the
7.28 commissioner, be renewed annually, and allow for recovery of costs and fees in pursuing
7.29 a claim on the bond.

7.30 **EFFECTIVE DATE.** This section is effective January 1, 2020.

8.1 Sec. 9. Minnesota Statutes 2018, section 119B.125, is amended by adding a subdivision
8.2 to read:

8.3 Subd. 11. **Financial misconduct.** (a) County agencies may conduct investigations of
8.4 financial misconduct by child care providers as described in section 245E.02, subdivisions
8.5 1 and 2, only after receiving verification that the department is not investigating a provider
8.6 under chapter 245E.

8.7 (b) If, upon investigation, a preponderance of evidence shows financial misconduct by
8.8 a provider, the county may immediately suspend the provider's authorization to receive
8.9 child care assistance payments under section 119B.13, subdivision 6, paragraph (d), prior
8.10 to pursuing other available remedies.

8.11 (c) The county shall give immediate notice in writing to a provider and any affected
8.12 families of any suspension of the provider's child care authorization under paragraph (b).
8.13 The notice shall state:

8.14 (1) the factual basis for the county's determination;

8.15 (2) the date of the suspension;

8.16 (3) the length of the suspension;

8.17 (4) the requirements and procedures for reinstatement;

8.18 (5) the right to dispute the county's determination and to provide evidence; and

8.19 (6) the right to appeal the county's determination.

8.20 (d) The county's determination under paragraph (b) is subject to the fair hearing
8.21 requirements under section 119B.16, subdivisions 1a, 1b, and 2. A provider that requests a
8.22 fair hearing is entitled to a hearing within ten days of the request.

8.23 Sec. 10. Minnesota Statutes 2018, section 119B.13, subdivision 6, is amended to read:

8.24 Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented
8.25 according to section 119B.125, subdivision 6. The provider shall bill for services provided
8.26 within ten days of the end of the service period. Payments under the child care fund shall
8.27 be made within 21 days of receiving a complete bill from the provider. Counties or the state
8.28 may establish policies that make payments on a more frequent basis.

8.29 (b) If a provider has received an authorization of care and been issued a billing form for
8.30 an eligible family, the bill must be submitted within 60 days of the last date of service on
8.31 the bill. A bill submitted more than 60 days after the last date of service must be paid if the

9.1 county determines that the provider has shown good cause why the bill was not submitted
 9.2 within 60 days. Good cause must be defined in the county's child care fund plan under
 9.3 section 119B.08, subdivision 3, and the definition of good cause must include county error.
 9.4 Any bill submitted more than a year after the last date of service on the bill must not be
 9.5 paid.

9.6 (c) If a provider provided care for a time period without receiving an authorization of
 9.7 care and a billing form for an eligible family, payment of child care assistance may only be
 9.8 made retroactively for a maximum of six months from the date the provider is issued an
 9.9 authorization of care and billing form.

9.10 (d) A county or the commissioner may refuse to issue a child care authorization to a
 9.11 licensed or legal nonlicensed provider, revoke an existing child care authorization to a
 9.12 licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed
 9.13 provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

9.14 (1) the provider admits to intentionally giving the county materially false information
 9.15 on the provider's billing forms;

9.16 (2) a county or the commissioner finds by a preponderance of the evidence that the
 9.17 provider intentionally gave the county materially false information on the provider's billing
 9.18 forms, or provided false attendance records to a county or the commissioner;

9.19 (3) the provider is in violation of child care assistance program rules, until the agency
 9.20 determines those violations have been corrected;

9.21 (4) the provider is operating after:

9.22 (i) an order of suspension of the provider's license issued by the commissioner;

9.23 (ii) an order of revocation of the provider's license; or

9.24 (iii) a final order of conditional license issued by the commissioner for as long as the
 9.25 conditional license is in effect;

9.26 (5) the provider submits false attendance reports or refuses to provide documentation
 9.27 of the child's attendance upon request; ~~or~~

9.28 (6) the provider gives false child care price information; or

9.29 (7) the provider fails to report decreases in a child's attendance, as required under section
 9.30 119B.125, subdivision 9.

10.1 (e) For purposes of paragraph (d), clauses (3), (5), ~~and (6)~~, and (7), the county or the
 10.2 commissioner may withhold the provider's authorization or payment for a period of time
 10.3 not to exceed three months beyond the time the condition has been corrected.

10.4 (f) A county's payment policies must be included in the county's child care plan under
 10.5 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
 10.6 compliance with this subdivision, the payments must be made in compliance with section
 10.7 16A.124.

10.8 **EFFECTIVE DATE.** This section is effective July 1, 2019.

10.9 Sec. 11. Minnesota Statutes 2018, section 119B.13, subdivision 7, is amended to read:

10.10 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
 10.11 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
 10.12 in a ~~fiscal~~ calendar year, or for more than ten consecutive full-day absent days. "Absent
 10.13 day" means any day that the child is authorized and scheduled to be in care with a licensed
 10.14 provider or license exempt center and the child is absent from the care for the entire day.
 10.15 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
 10.16 child attends for part of the time authorized to be in care in a day, but is absent for part of
 10.17 the time authorized to be in care in that same day, the absent time must be reimbursed but
 10.18 the time must not count toward the absent days limit. Child care providers must only be
 10.19 reimbursed for absent days if the provider has a written policy for child absences and charges
 10.20 all other families in care for similar absences.

10.21 (b) Notwithstanding paragraph (a), children with documented medical conditions that
 10.22 cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
 10.23 full-day absent days limit. Absences due to a documented medical condition of a parent or
 10.24 sibling who lives in the same residence as the child receiving child care assistance do not
 10.25 count against the absent days limit in a ~~fiscal~~ calendar year. Documentation of medical
 10.26 conditions must be on the forms and submitted according to the timelines established by
 10.27 the commissioner. A public health nurse or school nurse may verify the illness in lieu of a
 10.28 medical practitioner. If a provider sends a child home early due to a medical reason,
 10.29 including, but not limited to, fever or contagious illness, the child care center director or
 10.30 lead teacher may verify the illness in lieu of a medical practitioner.

10.31 (c) Notwithstanding paragraph (a), children in families may exceed the absent days limit
 10.32 if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or
 10.33 commissioner of education-selected high school equivalency certification; and (3) is a
 10.34 student in a school district or another similar program that provides or arranges for child

11.1 care, parenting support, social services, career and employment supports, and academic
11.2 support to achieve high school graduation, upon request of the program and approval of the
11.3 county. If a child attends part of an authorized day, payment to the provider must be for the
11.4 full amount of care authorized for that day.

11.5 (d) Child care providers must be reimbursed for up to ten federal or state holidays or
11.6 designated holidays per year when the provider charges all families for these days and the
11.7 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
11.8 Parents may substitute other cultural or religious holidays for the ten recognized state and
11.9 federal holidays. Holidays do not count toward the absent days limit.

11.10 (e) A family or child care provider must not be assessed an overpayment for an absent
11.11 day payment unless (1) there was an error in the amount of care authorized for the family,
11.12 (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family
11.13 or provider did not timely report a change as required under law.

11.14 (f) The provider and family shall receive notification of the number of absent days used
11.15 upon initial provider authorization for a family and ongoing notification of the number of
11.16 absent days used as of the date of the notification.

11.17 (g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days
11.18 per child, excluding holidays, in a ~~fiscal~~ calendar year; and ten consecutive full-day absent
11.19 days.

11.20 (h) For purposes of this subdivision, "holidays limit" means ten full-day holidays per
11.21 child, excluding absent days, in a calendar year.

11.22 (i) If a day meets the criteria of an absent day or a holiday under this subdivision, the
11.23 provider must bill that day as an absent day or holiday. A provider's failure to properly bill
11.24 an absent day or a holiday results in an overpayment, regardless of whether the child reached,
11.25 or is exempt from, the absent days limit or holidays limit for the calendar year.

11.26 **EFFECTIVE DATE.** This section is effective July 1, 2019.

11.27 Sec. 12. Minnesota Statutes 2018, section 144A.479, is amended by adding a subdivision
11.28 to read:

11.29 Subd. 8. **Labor market reporting.** A home care provider shall comply with the labor
11.30 market reporting requirements described in section 256B.4912, subdivision 1a.

12.1 Sec. 13. Minnesota Statutes 2018, section 245.095, is amended to read:

12.2 **245.095 LIMITS ON RECEIVING PUBLIC FUNDS.**

12.3 Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed,
 12.4 ~~or receiving funds under a grant contract, or registered~~ in any program administered by the
 12.5 commissioner, including under the commissioner's powers and authorities in section 256.01,
 12.6 is excluded from any that program administered by the commissioner, including under the
 12.7 ~~commissioner's powers and authorities in section 256.01,~~ the commissioner shall:

12.8 (1) prohibit the excluded provider, vendor, or individual from enrolling or becoming
 12.9 licensed, receiving grant funds, or registering in any other program administered by the
 12.10 commissioner; and

12.11 (2) disenroll, revoke or suspend a license, disqualify, or debar the excluded provider,
 12.12 vendor, or individual in any other program administered by the commissioner.

12.13 (b) The duration of this prohibition, disenrollment, revocation, suspension,
 12.14 disqualification, or debarment must last for the longest applicable sanction or disqualifying
 12.15 period in effect for the provider, vendor, or individual permitted by state or federal law.

12.16 Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions have the
 12.17 meanings given them.

12.18 (b) "Excluded" means disenrolled, ~~subject to license revocation or suspension,~~
 12.19 ~~disqualified, or subject to vendor debarment~~ disqualified, has a license that has been revoked
 12.20 or suspended under chapter 245A, has been debarred or suspended under Minnesota Rules,
 12.21 part 1230.1150, or terminated from participation in medical assistance under section
 12.22 256B.064.

12.23 (c) "Individual" means a natural person providing products or services as a provider or
 12.24 vendor.

12.25 (d) "Provider" means an owner, controlling individual, license holder, director, or
 12.26 managerial official.

12.27 Sec. 14. **[245A.24] MANDATORY REPORTING.**

12.28 All licensors employed by a county or the Department of Human Services must
 12.29 immediately report any suspected fraud to county human services investigators or the
 12.30 Department of Human Services Office of the Inspector General.

13.1 Sec. 15. Minnesota Statutes 2018, section 245E.02, is amended by adding a subdivision
13.2 to read:

13.3 Subd. 1a. **Provider definitions.** For the purposes of this section, "provider" includes:

13.4 (1) individuals or entities meeting the definition of provider in section 245E.01,
13.5 subdivision 12; and

13.6 (2) owners and controlling individuals of entities identified in clause (1).

13.7 Sec. 16. Minnesota Statutes 2018, section 256.98, subdivision 1, is amended to read:

13.8 Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the
13.9 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
13.10 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
13.11 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
13.12 256L, child care assistance programs, and emergency assistance programs under section
13.13 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
13.14 (1) to (5):

13.15 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
13.16 willfully false statement or representation, by intentional concealment of any material fact,
13.17 or by impersonation or other fraudulent device, assistance or the continued receipt of
13.18 assistance, to include child care assistance or vouchers produced according to sections
13.19 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94,
13.20 and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that
13.21 to which the person is entitled;

13.22 (2) knowingly aids or abets in buying or in any way disposing of the property of a
13.23 recipient or applicant of assistance without the consent of the county agency; or

13.24 (3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments
13.25 to which the individual is not entitled as a provider of subsidized child care, or by furnishing
13.26 or concurring in a willfully false claim for child care assistance.

13.27 The continued receipt of assistance to which the person is not entitled or greater than
13.28 that to which the person is entitled as a result of any of the acts, failure to act, or concealment
13.29 described in this subdivision shall be deemed to be continuing offenses from the date that
13.30 the first act or failure to act occurred.

14.1 Sec. 17. Minnesota Statutes 2018, section 256.98, subdivision 8, is amended to read:

14.2 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
 14.3 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
 14.4 determination, or waiver thereof, through a disqualification consent agreement, or as part
 14.5 of any approved diversion plan under section 401.065, or any court-ordered stay which
 14.6 carries with it any probationary or other conditions, in the Minnesota family investment
 14.7 program and any affiliated program to include the diversionary work program and the work
 14.8 participation cash benefit program, the food stamp or food support program, the general
 14.9 assistance program, housing support under chapter 256I, or the Minnesota supplemental
 14.10 aid program shall be disqualified from that program. The disqualification based on a finding
 14.11 or action by a federal or state court is a permanent disqualification. The disqualification
 14.12 based on an administrative hearing, or waiver thereof, through a disqualification consent
 14.13 agreement, or as part of any approved diversion plan under section 401.065, or any
 14.14 court-ordered stay which carries with it any probationary or other conditions must be for a
 14.15 period of two years for the first offense and a permanent disqualification for the second
 14.16 offense. In addition, any person disqualified from the Minnesota family investment program
 14.17 shall also be disqualified from the food stamp or food support program. The needs of that
 14.18 individual shall not be taken into consideration in determining the grant level for that
 14.19 assistance unit.

14.20 ~~(1) for one year after the first offense;~~

14.21 ~~(2) for two years after the second offense; and~~

14.22 ~~(3) permanently after the third or subsequent offense.~~

14.23 The period of program disqualification shall begin on the date stipulated on the advance
 14.24 notice of disqualification without possibility of postponement for administrative stay or
 14.25 administrative hearing and shall continue through completion unless and until the findings
 14.26 upon which the sanctions were imposed are reversed by a court of competent jurisdiction.
 14.27 The period for which sanctions are imposed is not subject to review. The sanctions provided
 14.28 under this subdivision are in addition to, and not in substitution for, any other sanctions that
 14.29 may be provided for by law for the offense involved. A disqualification established through
 14.30 hearing or waiver shall result in the disqualification period beginning immediately unless
 14.31 the person has become otherwise ineligible for assistance. If the person is ineligible for
 14.32 assistance, the disqualification period begins when the person again meets the eligibility
 14.33 criteria of the program from which they were disqualified and makes application for that
 14.34 program.

15.1 (b) A family receiving assistance through child care assistance programs under chapter
15.2 119B with a family member who is found to be guilty of wrongfully obtaining child care
15.3 assistance by a federal court, state court, or an administrative hearing determination or
15.4 waiver, through a disqualification consent agreement, as part of an approved diversion plan
15.5 under section 401.065, or a court-ordered stay with probationary or other conditions, is
15.6 disqualified from child care assistance programs. ~~The disqualifications must be for periods~~
15.7 ~~of one year and two years for the first and second offenses, respectively. Subsequent~~
15.8 ~~violations must result in~~ based on a finding or action by a federal or state court is a permanent
15.9 disqualification. The disqualification based on an administrative hearing determination or
15.10 waiver, through a disqualification consent agreement, as part of an approved diversion plan
15.11 under section 401.065, or a court-ordered stay with probationary or other conditions must
15.12 be for a period of two years for the first offense and a permanent disqualification for the
15.13 second offense. During the disqualification period, disqualification from any child care
15.14 program must extend to all child care programs and must be immediately applied.

15.15 (c) A provider caring for children receiving assistance through child care assistance
15.16 programs under chapter 119B is disqualified from receiving payment for child care services
15.17 from the child care assistance program under chapter 119B when the provider is found to
15.18 have wrongfully obtained child care assistance by a federal court, state court, or an
15.19 administrative hearing determination or waiver under section 256.046, through a
15.20 disqualification consent agreement, as part of an approved diversion plan under section
15.21 401.065, or a court-ordered stay with probationary or other conditions. ~~The disqualification~~
15.22 ~~must be for a period of one year for the first offense and two years for the second offense.~~
15.23 ~~Any subsequent violation must result in~~ based on a finding or action by a federal or state
15.24 court is a permanent disqualification. The disqualification based on an administrative hearing
15.25 determination or waiver under section 256.045, as part of an approved diversion plan under
15.26 section 401.065, or a court-ordered stay with probationary or other conditions must be for
15.27 a period of two years for the first offense and a permanent disqualification for the second
15.28 offense. The disqualification period must be imposed immediately after a determination is
15.29 made under this paragraph. During the disqualification period, the provider is disqualified
15.30 from receiving payment from any child care program under chapter 119B.

15.31 (d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults
15.32 without children and upon federal approval, all categories of medical assistance and
15.33 remaining categories of MinnesotaCare, except for children through age 18, by a federal or
15.34 state court or by an administrative hearing determination, or waiver thereof, through a
15.35 disqualification consent agreement, or as part of any approved diversion plan under section

16.1 401.065, or any court-ordered stay which carries with it any probationary or other conditions,
16.2 is disqualified from that program. The period of disqualification is one year after the first
16.3 offense, two years after the second offense, and permanently after the third or subsequent
16.4 offense. The period of program disqualification shall begin on the date stipulated on the
16.5 advance notice of disqualification without possibility of postponement for administrative
16.6 stay or administrative hearing and shall continue through completion unless and until the
16.7 findings upon which the sanctions were imposed are reversed by a court of competent
16.8 jurisdiction. The period for which sanctions are imposed is not subject to review. The
16.9 sanctions provided under this subdivision are in addition to, and not in substitution for, any
16.10 other sanctions that may be provided for by law for the offense involved.

16.11 Sec. 18. Minnesota Statutes 2018, section 256.987, subdivision 1, is amended to read:

16.12 Subdivision 1. **Electronic benefit transfer (EBT) card.** Cash benefits for the general
16.13 assistance and Minnesota supplemental aid programs under chapter 256D and programs
16.14 under chapter 256J must be issued on an EBT card ~~with~~. The name and photograph of the
16.15 head of household and a list of family members authorized to use the EBT card must be
16.16 printed on the card. The cardholder must show identification before making a purchase.
16.17 The card must include the following statement: "It is unlawful to use this card to purchase
16.18 tobacco products or alcoholic beverages." This card must be issued within 30 calendar days
16.19 of an eligibility determination. During the initial 30 calendar days of eligibility, a recipient
16.20 may have cash benefits issued on an EBT card without a name printed on the card. This
16.21 card may be the same card on which food support benefits are issued and does not need to
16.22 meet the requirements of this section.

16.23 Sec. 19. Minnesota Statutes 2018, section 256.987, subdivision 2, is amended to read:

16.24 Subd. 2. **Prohibited purchases and returns.** (a) An individual with an EBT card issued
16.25 for one of the programs listed under subdivision 1 is prohibited from using the EBT debit
16.26 card to purchase tobacco products and alcoholic beverages, as defined in section 340A.101,
16.27 subdivision 2. Any prohibited purchases made under this subdivision shall constitute unlawful
16.28 use and result in disqualification of the cardholder from the program as provided in
16.29 subdivision 4.

16.30 (b) An item purchased with an EBT card that is returned must be credited back to the
16.31 EBT card. It is prohibited to give the EBT cardholder cash for returned items purchased
16.32 with an EBT card.

17.1 Sec. 20. Minnesota Statutes 2018, section 256B.02, subdivision 7, is amended to read:

17.2 Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or
17.3 persons furnishing, within the scope of the vendor's respective license, any or all of the
17.4 following goods or services: medical, surgical, hospital, ambulatory surgical center services,
17.5 optical, visual, dental and nursing services; drugs and medical supplies; appliances;
17.6 laboratory, diagnostic, and therapeutic services; nursing home and convalescent care;
17.7 screening and health assessment services provided by public health nurses as defined in
17.8 section 145A.02, subdivision 18; health care services provided at the residence of the patient
17.9 if the services are performed by a public health nurse and the nurse indicates in a statement
17.10 submitted under oath that the services were actually provided; and such other medical
17.11 services or supplies provided or prescribed by persons authorized by state law to give such
17.12 services and supplies, including services under section 256B.4912. For purposes of this
17.13 chapter, the term includes a person or entity that furnishes a good or service eligible for
17.14 medical assistance or federally approved waiver plan payments under this chapter. The term
17.15 includes, but is not limited to, directors and officers of corporations or members of
17.16 partnerships who, either individually or jointly with another or others, have the legal control,
17.17 supervision, or responsibility of submitting claims for reimbursement to the medical
17.18 assistance program. The term only includes directors and officers of corporations who
17.19 personally receive a portion of the distributed assets upon liquidation or dissolution, and
17.20 their liability is limited to the portion of the claim that bears the same proportion to the total
17.21 claim as their share of the distributed assets bears to the total distributed assets.

17.22 (b) "Vendor of medical care" also includes any person who is credentialed as a health
17.23 professional under standards set by the governing body of a federally recognized Indian
17.24 tribe authorized under an agreement with the federal government according to United States
17.25 Code, title 25, section 450f, to provide health services to its members, and who through a
17.26 tribal facility provides covered services to American Indian people within a contract health
17.27 service delivery area of a Minnesota reservation, as defined under Code of Federal
17.28 Regulations, title 42, section 36.22.

17.29 (c) A federally recognized Indian tribe that intends to implement standards for
17.30 credentialing health professionals must submit the standards to the commissioner of human
17.31 services, along with evidence of meeting, exceeding, or being exempt from corresponding
17.32 state standards. The commissioner shall maintain a copy of the standards and supporting
17.33 evidence, and shall use those standards to enroll tribal-approved health professionals as
17.34 medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean
17.35 persons or entities that meet the definition in United States Code, title 25, section 450b.

18.1 Sec. 21. Minnesota Statutes 2018, section 256B.02, is amended by adding a subdivision
18.2 to read:

18.3 Subd. 20. **Income.** Income is calculated using the adjusted gross income methodology
18.4 under the Affordable Care Act. Income includes funds in personal or business accounts
18.5 used to pay personal expenses including rent, mortgage, automobile-related expenses,
18.6 utilities, food, and other personal expenses not directly related to the business, unless the
18.7 funds are directly attributable to an exception to the income requirement specifically
18.8 identified by the applicant.

18.9 Sec. 22. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

18.10 Subd. 21. **Provider enrollment.** (a) The commissioner shall enroll providers and conduct
18.11 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
18.12 E, including database checks, unannounced pre- and post-enrollment site visits, fingerprinting,
18.13 and criminal background studies. A provider providing services from multiple licensed
18.14 locations must enroll each licensed location separately. The commissioner may deny a
18.15 provider's incomplete application for enrollment if a provider fails to respond to the
18.16 commissioner's request for additional information within 60 days of the request.

18.17 (b) The commissioner must revalidate each provider under this subdivision at least once
18.18 every five years. The commissioner may revalidate a personal care assistance agency under
18.19 this subdivision once every three years. The commissioner shall conduct revalidation as
18.20 follows:

18.21 (1) provide 30-day notice of revalidation due date to include instructions for revalidation
18.22 and a list of materials the provider must submit to revalidate;

18.23 (2) notify the provider that fails to completely respond within 30 days of any deficiencies
18.24 and allow an additional 30 days to comply; and

18.25 (3) give 60-day notice of termination and immediately suspend a provider's ability to
18.26 bill for failure to remedy any deficiencies within the 30-day time period. The commissioner's
18.27 decision to suspend the provider's ability to bill is not subject to an administrative appeal.

18.28 (c) The commissioner shall require that an individual rendering care to a recipient for
18.29 the following covered services enroll as an individual provider and be identified on claims:

18.30 (1) consumer directed community supports; and

18.31 (2) qualified professionals supervising personal care assistant services according to
18.32 section 256B.0659.

19.1 (d) The commissioner may suspend a provider's ability to bill for a failure to comply
19.2 with any individual provider requirements or conditions of participation until the provider
19.3 comes into compliance. The commissioner's decision to suspend the provider's ability to
19.4 bill is not subject to an administrative appeal.

19.5 (e) Notwithstanding any other provision to the contrary, all correspondence and
19.6 notifications, including notifications of termination and other actions, shall be delivered
19.7 electronically to a provider's MN-ITS mailbox. For a provider that does not have a MN-ITS
19.8 account and mailbox, notice shall be sent by first class mail.

19.9 (f) If the commissioner or the Centers for Medicare and Medicaid Services determines
19.10 that a provider is designated "high-risk," the commissioner may withhold payment from
19.11 providers within that category upon initial enrollment for a 90-day period. The withholding
19.12 for each provider must begin on the date of the first submission of a claim.

19.13 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter
19.14 245A, or is licensed as a home care provider by the Department of Health under chapter
19.15 144A and has a home and community-based services designation on the home care license
19.16 under section 144A.484, must designate an individual as the entity's compliance officer.
19.17 The compliance officer must:

19.18 (1) develop policies and procedures to assure adherence to medical assistance laws and
19.19 regulations and to prevent inappropriate claims submissions;

19.20 (2) train the employees of the provider entity, and any agents or subcontractors of the
19.21 provider entity including billers, on the policies and procedures under clause (1);

19.22 (3) respond to allegations of improper conduct related to the provision or billing of
19.23 medical assistance services, and implement action to remediate any resulting problems;

19.24 (4) use evaluation techniques to monitor compliance with medical assistance laws and
19.25 regulations;

19.26 (5) promptly report to the commissioner any identified violations of medical assistance
19.27 laws or regulations; and

19.28 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
19.29 overpayment, report the overpayment to the commissioner and make arrangements with
19.30 the commissioner for the commissioner's recovery of the overpayment.

19.31 The commissioner may require, as a condition of enrollment in medical assistance, that a
19.32 provider within a particular industry sector or category establish a compliance program that
19.33 contains the core elements established by the Centers for Medicare and Medicaid Services.

20.1 ~~(e)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider
20.2 for a period of not more than one year, if the provider fails to maintain and, upon request
20.3 from the commissioner, provide access to documentation relating to written orders or requests
20.4 for payment for durable medical equipment, certifications for home health services, or
20.5 referrals for other items or services written or ordered by such provider, when the
20.6 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
20.7 to maintain documentation or provide access to documentation on more than one occasion.
20.8 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
20.9 under the provisions of section 256B.064.

20.10 ~~(d)~~ (i) The commissioner shall terminate or deny the enrollment of any individual or
20.11 entity if the individual or entity has been terminated from participation in Medicare or under
20.12 the Medicaid program or Children's Health Insurance Program of any other state.

20.13 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require
20.14 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
20.15 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
20.16 Services, its agents, or its designated contractors and the state agency, its agents, or its
20.17 designated contractors to conduct unannounced on-site inspections of any provider location.
20.18 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
20.19 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
20.20 and standards used to designate Medicare providers in Code of Federal Regulations, title
20.21 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
20.22 The commissioner's designations are not subject to administrative appeal.

20.23 ~~(f)~~ (k) As a condition of enrollment in medical assistance, the commissioner shall require
20.24 that a high-risk provider, or a person with a direct or indirect ownership interest in the
20.25 provider of five percent or higher, consent to criminal background checks, including
20.26 fingerprinting, when required to do so under state law or by a determination by the
20.27 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated
20.28 high-risk for fraud, waste, or abuse.

20.29 ~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
20.30 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
20.31 meeting the durable medical equipment provider and supplier definition in clause (3),
20.32 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
20.33 annually renewed and designates the Minnesota Department of Human Services as the
20.34 obligee, and must be submitted in a form approved by the commissioner. For purposes of
20.35 this clause, the following medical suppliers are not required to obtain a surety bond: a

21.1 federally qualified health center, a home health agency, the Indian Health Service, a
21.2 pharmacy, and a rural health clinic.

21.3 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
21.4 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
21.5 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
21.6 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
21.7 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
21.8 purchase a surety bond of \$100,000. The surety bond must ~~allow for recovery of costs and~~
21.9 ~~fees in pursuing a claim on the bond~~ be in a form approved by the commissioner, renewed
21.10 annually, and must allow for recovery of costs and fees in pursuing a claim on the bond.

21.11 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
21.12 purchase medical equipment or supplies for sale or rental to the general public and is able
21.13 to perform or arrange for necessary repairs to and maintenance of equipment offered for
21.14 sale or rental.

21.15 ~~(h)~~ (m) The Department of Human Services may require a provider to purchase a surety
21.16 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
21.17 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
21.18 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
21.19 provider or category of providers is designated high-risk pursuant to paragraph ~~(a)~~ (e) and
21.20 as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in
21.21 an amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
21.22 immediately preceding 12 months, whichever is greater. The surety bond must name the
21.23 Department of Human Services as an obligee and must allow for recovery of costs and fees
21.24 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
21.25 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

21.26 **EFFECTIVE DATE.** This section is effective July 1, 2019, with the exception that the
21.27 amendments to paragraph (1), clause (2), are effective January 1, 2020.

21.28 Sec. 23. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

21.29 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
21.30 assistance, a person must not individually own more than \$3,000 in assets, or if a member
21.31 of a household with two family members, husband and wife, or parent and child, the
21.32 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
21.33 dependent. In addition to these maximum amounts, an eligible individual or family may
21.34 accrue interest on these amounts, but they must be reduced to the maximum at the time of

22.1 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
22.2 according to section 256B.35 must also be reduced to the maximum at the time of the
22.3 eligibility redetermination. The value of assets that are not considered in determining
22.4 eligibility for medical assistance is the value of those assets excluded under the Supplemental
22.5 Security Income program for aged, blind, and disabled persons, with the following
22.6 exceptions:

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

22.8 (2) capital and operating assets of a trade or business that the local agency determines
22.9 are necessary to the person's ability to earn an income are not considered. A bank account
22.10 that contains personal income or assets or is used to pay personal expenses is not a capital
22.11 or operating asset of a trade or business;

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

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

22.18 (5) for a person who no longer qualifies as an employed person with a disability due to
22.19 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
22.20 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
22.21 as an employed person with a disability, to the extent that the person's total assets remain
22.22 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

22.23 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
22.24 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before
22.25 the person's 65th birthday, the assets owned by the person and the person's spouse must be
22.26 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when
22.27 determining eligibility for medical assistance under section 256B.055, subdivision 7. The
22.28 income of a spouse of a person enrolled in medical assistance under section 256B.057,
22.29 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
22.30 must be disregarded when determining eligibility for medical assistance under section
22.31 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
22.32 in section 256B.059; and

22.33 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
22.34 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

23.1 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
23.2 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

23.3 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
23.4 15.

23.5 Sec. 24. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

23.6 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
23.7 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
23.8 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
23.9 Supplemental Security Income may have an income up to the Supplemental Security Income
23.10 standard in effect on that date.

23.11 (b) Effective January 1, 2014, to be eligible for medical assistance, under section
23.12 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
23.13 percent of the federal poverty guidelines for the household size.

23.14 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a
23.15 person may have an income up to 133 percent of federal poverty guidelines for the household
23.16 size.

23.17 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child
23.18 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for
23.19 the household size.

23.20 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
23.21 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
23.22 household size or an equivalent standard when converted using modified adjusted gross
23.23 income methodology as required under the Affordable Care Act. Children who are enrolled
23.24 in medical assistance as of December 31, 2013, and are determined ineligible for medical
23.25 assistance because of the elimination of income disregards under modified adjusted gross
23.26 income methodology as defined in subdivision 1a remain eligible for medical assistance
23.27 under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law
23.28 111-3, until the date of their next regularly scheduled eligibility redetermination as required
23.29 in subdivision 7a.

23.30 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
23.31 who are not residents of long-term care facilities, the commissioner shall: (1) disregard
23.32 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.
23.33 For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans

24.1 Administration unusual medical expense payments are considered income to the recipient;
 24.2 and (2) include all assets available to the applicant that are considered income according to
 24.3 the Internal Revenue Service. Income includes all deposits into accounts owned or controlled
 24.4 by the applicant, including amounts spent on personal expenses, including rent, mortgage,
 24.5 automobile-related expenses, utilities, and food and amounts received as salary or draws
 24.6 from business accounts and not otherwise excluded by federal or state laws. Income does
 24.7 not include a deposit specifically identified by the applicant as a loan or gift, for which the
 24.8 applicant provides the source, date, amount, and repayment terms.

24.9 Sec. 25. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

24.10 Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual
 24.11 redetermination of eligibility ~~based on information contained in the enrollee's case file and~~
 24.12 ~~other information available to the agency, including but not limited to information accessed~~
 24.13 ~~through an electronic database, without requiring the enrollee to submit any information~~
 24.14 ~~when sufficient data is available for the agency to renew eligibility.~~

24.15 (b) ~~If the commissioner cannot renew eligibility in accordance with paragraph (a),~~ The
 24.16 commissioner must provide the enrollee with a prepopulated renewal form containing
 24.17 eligibility information available to the agency and ~~permit~~ the enrollee to must submit the
 24.18 form with any corrections or additional information to the agency and sign the renewal form
 24.19 via any of the modes of submission specified in section 256B.04, subdivision 18.

24.20 (c) An enrollee who is terminated for failure to complete the renewal process may
 24.21 subsequently submit the renewal form and required information within four months after
 24.22 the date of termination and have coverage reinstated without a lapse, if otherwise eligible
 24.23 under this chapter.

24.24 (d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be
 24.25 required to renew eligibility every six months.

24.26 Sec. 26. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

24.27 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
 24.28 means motor vehicle transportation provided by a public or private person that serves
 24.29 Minnesota health care program beneficiaries who do not require emergency ambulance
 24.30 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

24.31 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
 24.32 emergency medical care or transportation costs incurred by eligible persons in obtaining

25.1 emergency or nonemergency medical care when paid directly to an ambulance company,
 25.2 nonemergency medical transportation company, or other recognized providers of
 25.3 transportation services. Medical transportation must be provided by:

25.4 (1) nonemergency medical transportation providers who meet the requirements of this
 25.5 subdivision;

25.6 (2) ambulances, as defined in section 144E.001, subdivision 2;

25.7 (3) taxicabs that meet the requirements of this subdivision;

25.8 (4) public transit, as defined in section 174.22, subdivision 7; or

25.9 (5) not-for-hire vehicles, including volunteer drivers.

25.10 (c) Medical assistance covers nonemergency medical transportation provided by
 25.11 nonemergency medical transportation providers enrolled in the Minnesota health care
 25.12 programs. All nonemergency medical transportation providers must comply with the
 25.13 operating standards for special transportation service as defined in sections 174.29 to 174.30
 25.14 and Minnesota Rules, chapter 8840, ~~and in consultation with the Minnesota Department of~~
 25.15 ~~Transportation.~~ All drivers providing nonemergency medical transportation must be
 25.16 individually enrolled with the commissioner if the driver is a subcontractor for or employed
 25.17 by a provider that both has a base of operation located within a metropolitan county listed
 25.18 in section 473.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All
 25.19 nonemergency medical transportation providers shall bill for nonemergency medical
 25.20 transportation services in accordance with Minnesota health care programs criteria. Publicly
 25.21 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
 25.22 requirements outlined in this paragraph.

25.23 (d) An organization may be terminated, denied, or suspended from enrollment if:

25.24 (1) the provider has not initiated background studies on the individuals specified in
 25.25 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

25.26 (2) the provider has initiated background studies on the individuals specified in section
 25.27 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

25.28 (i) the commissioner has sent the provider a notice that the individual has been
 25.29 disqualified under section 245C.14; and

25.30 (ii) the individual has not received a disqualification set-aside specific to the special
 25.31 transportation services provider under sections 245C.22 and 245C.23.

25.32 (e) The administrative agency of nonemergency medical transportation must:

- 26.1 (1) adhere to the policies defined by the commissioner in consultation with the
26.2 Nonemergency Medical Transportation Advisory Committee;
- 26.3 (2) pay nonemergency medical transportation providers for services provided to
26.4 Minnesota health care programs beneficiaries to obtain covered medical services;
- 26.5 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
26.6 trips, and number of trips by mode; and
- 26.7 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
26.8 administrative structure assessment tool that meets the technical requirements established
26.9 by the commissioner, reconciles trip information with claims being submitted by providers,
26.10 and ensures prompt payment for nonemergency medical transportation services.
- 26.11 (f) Until the commissioner implements the single administrative structure and delivery
26.12 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
26.13 commissioner or an entity approved by the commissioner that does not dispatch rides for
26.14 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).
- 26.15 (g) The commissioner may use an order by the recipient's attending physician or a medical
26.16 or mental health professional to certify that the recipient requires nonemergency medical
26.17 transportation services. Nonemergency medical transportation providers shall perform
26.18 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
26.19 includes passenger pickup at and return to the individual's residence or place of business,
26.20 assistance with admittance of the individual to the medical facility, and assistance in
26.21 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.
- 26.22 Nonemergency medical transportation providers must take clients to the health care
26.23 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
26.24 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
26.25 authorization from the local agency.
- 26.26 Nonemergency medical transportation providers may not bill for separate base rates for
26.27 the continuation of a trip beyond the original destination. Nonemergency medical
26.28 transportation providers must maintain trip logs, which include pickup and drop-off times,
26.29 signed by the medical provider or client, whichever is deemed most appropriate, attesting
26.30 to mileage traveled to obtain covered medical services. Clients requesting client mileage
26.31 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
26.32 services.

27.1 (h) The administrative agency shall use the level of service process established by the
27.2 commissioner in consultation with the Nonemergency Medical Transportation Advisory
27.3 Committee to determine the client's most appropriate mode of transportation. If public transit
27.4 or a certified transportation provider is not available to provide the appropriate service mode
27.5 for the client, the client may receive a onetime service upgrade.

27.6 (i) The covered modes of transportation are:

27.7 (1) client reimbursement, which includes client mileage reimbursement provided to
27.8 clients who have their own transportation, or to family or an acquaintance who provides
27.9 transportation to the client;

27.10 (2) volunteer transport, which includes transportation by volunteers using their own
27.11 vehicle;

27.12 (3) unassisted transport, which includes transportation provided to a client by a taxicab
27.13 or public transit. If a taxicab or public transit is not available, the client can receive
27.14 transportation from another nonemergency medical transportation provider;

27.15 (4) assisted transport, which includes transport provided to clients who require assistance
27.16 by a nonemergency medical transportation provider;

27.17 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
27.18 dependent on a device and requires a nonemergency medical transportation provider with
27.19 a vehicle containing a lift or ramp;

27.20 (6) protected transport, which includes transport provided to a client who has received
27.21 a prescreening that has deemed other forms of transportation inappropriate and who requires
27.22 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
27.23 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
27.24 the vehicle driver; and (ii) who is certified as a protected transport provider; and

27.25 (7) stretcher transport, which includes transport for a client in a prone or supine position
27.26 and requires a nonemergency medical transportation provider with a vehicle that can transport
27.27 a client in a prone or supine position.

27.28 (j) The local agency shall be the single administrative agency and shall administer and
27.29 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
27.30 commissioner has developed, made available, and funded the web-based single administrative
27.31 structure, assessment tool, and level of need assessment under subdivision 18e. The local
27.32 agency's financial obligation is limited to funds provided by the state or federal government.

27.33 (k) The commissioner shall:

28.1 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
28.2 verify that the mode and use of nonemergency medical transportation is appropriate;

28.3 (2) verify that the client is going to an approved medical appointment; and

28.4 (3) investigate all complaints and appeals.

28.5 (l) The administrative agency shall pay for the services provided in this subdivision and
28.6 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
28.7 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
28.8 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

28.9 (m) Payments for nonemergency medical transportation must be paid based on the client's
28.10 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
28.11 medical assistance reimbursement rates for nonemergency medical transportation services
28.12 that are payable by or on behalf of the commissioner for nonemergency medical
28.13 transportation services are:

28.14 (1) \$0.22 per mile for client reimbursement;

28.15 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
28.16 transport;

28.17 (3) equivalent to the standard fare for unassisted transport when provided by public
28.18 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
28.19 medical transportation provider;

28.20 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

28.21 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

28.22 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

28.23 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
28.24 an additional attendant if deemed medically necessary.

28.25 (n) The base rate for nonemergency medical transportation services in areas defined
28.26 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
28.27 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
28.28 services in areas defined under RUCA to be rural or super rural areas is:

28.29 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
28.30 rate in paragraph (m), clauses (1) to (7); and

29.1 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
29.2 rate in paragraph (m), clauses (1) to (7).

29.3 (o) For purposes of reimbursement rates for nonemergency medical transportation
29.4 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
29.5 shall determine whether the urban, rural, or super rural reimbursement rate applies.

29.6 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
29.7 a census-tract based classification system under which a geographical area is determined
29.8 to be urban, rural, or super rural.

29.9 (q) The commissioner, when determining reimbursement rates for nonemergency medical
29.10 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
29.11 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

29.12 **EFFECTIVE DATE.** This section is effective January 1, 2020.

29.13 Sec. 27. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
29.14 to read:

29.15 **Subd. 17d. Transportation services oversight.** The commissioner shall contract with
29.16 a vendor or dedicate staff for oversight of providers of nonemergency medical transportation
29.17 services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules,
29.18 parts 9505.2160 to 9505.2245.

29.19 **EFFECTIVE DATE.** This section is effective January 1, 2020.

29.20 Sec. 28. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
29.21 to read:

29.22 **Subd. 17e. Transportation provider termination.** (a) A terminated nonemergency
29.23 medical transportation provider, including all named individuals on the current enrollment
29.24 disclosure form and known or discovered affiliates of the nonemergency medical
29.25 transportation provider, is not eligible to enroll as a nonemergency medical transportation
29.26 provider for five years following the termination.

29.27 (b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a
29.28 nonemergency medical transportation provider, the nonemergency medical transportation
29.29 provider must be placed on a one-year probation period. During a provider's probation
29.30 period, the commissioner shall complete unannounced site visits and request documentation
29.31 to review compliance with program requirements.

30.1 Sec. 29. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
30.2 to read:

30.3 Subd. 17f. **Transportation provider training.** The commissioner shall make available
30.4 to providers of nonemergency medical transportation and all drivers training materials and
30.5 online training opportunities regarding documentation requirements, documentation
30.6 procedures, and penalties for failing to meet documentation requirements.

30.7 Sec. 30. Minnesota Statutes 2018, section 256B.0625, subdivision 18h, is amended to
30.8 read:

30.9 Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans
30.10 and county-based purchasing plans:

30.11 (1) subdivision 17, paragraphs (a), (b), (c), (i), and (n);

30.12 (2) subdivision 18; and

30.13 (3) subdivision 18a.

30.14 ~~(b) A nonemergency medical transportation provider must comply with the operating~~
30.15 ~~standards for special transportation service specified in sections 174.29 to 174.30 and~~
30.16 ~~Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire~~
30.17 ~~vehicles are exempt from the requirements in this paragraph.~~

30.18 Sec. 31. Minnesota Statutes 2018, section 256B.0625, subdivision 43, is amended to read:

30.19 Subd. 43. **Mental health provider travel time.** (a) Medical assistance covers provider
30.20 travel time if a ~~recipient's individual treatment plan~~ recipient requires the provision of mental
30.21 health services outside of the provider's ~~normal~~ usual place of business. ~~This does not include~~
30.22 ~~any travel time which is included in other billable services, and is only covered when the~~
30.23 ~~mental health service being provided to a recipient is covered under medical assistance.~~

30.24 (b) Medical assistance covers under this subdivision the time a provider is in transit to
30.25 provide a covered mental health service to a recipient at a location that is not the provider's
30.26 usual place of business. A provider must travel the most direct route available. Mental health
30.27 provider travel time does not include time for scheduled or unscheduled stops, meal breaks,
30.28 or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient
30.29 transportation is not covered under this subdivision.

30.30 (c) Mental health provider travel time under this subdivision is only covered when the
30.31 mental health service being provided is covered under medical assistance and only when

31.1 the covered mental health service is delivered and billed. Mental health provider travel time
 31.2 is not covered when the mental health service being provided otherwise includes provider
 31.3 travel time or when the service is site based.

31.4 (d) A provider must document each trip for which the provider seeks reimbursement
 31.5 under this subdivision in a compiled travel record. Required documentation may be collected
 31.6 and maintained electronically or in paper form but must be made available and produced
 31.7 upon request by the commissioner. The travel record must be written in English and must
 31.8 be legible according to the standard of a reasonable person. The recipient's individual
 31.9 identification number must be on each page of the record. The reason the provider must
 31.10 travel to provide services must be included in the record, if not otherwise documented in
 31.11 the recipient's individual treatment plan. Each entry in the record must document:

31.12 (1) start and stop time (with a.m. and p.m. notations);

31.13 (2) printed name of the recipient;

31.14 (3) date the entry is made;

31.15 (4) date the service is provided;

31.16 (5) origination site and destination site;

31.17 (6) who provided the service;

31.18 (7) the electronic source used to calculate driving directions and distance between
 31.19 locations; and

31.20 (8) the medically necessary mental health service delivered.

31.21 (e) Mental health providers identified by the commissioner to have submitted a fraudulent
 31.22 report may be excluded from participation in Minnesota health care programs.

31.23 Sec. 32. Minnesota Statutes 2018, section 256B.064, subdivision 1b, is amended to read:

31.24 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions
 31.25 for the conduct described in subdivision 1a: suspension or withholding of payments to a
 31.26 vendor and suspending or terminating participation in the program, or imposition of a fine
 31.27 under subdivision 2, paragraph (f). When imposing sanctions under this section, the
 31.28 commissioner shall consider the nature, chronicity, or severity of the conduct and the effect
 31.29 of the conduct on the health and safety of persons served by the vendor. The commissioner
 31.30 shall suspend a vendor's participation in the program for a minimum of five years if the
 31.31 vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered
 31.32 diversion program for an offense related to a provision of a health service under medical

32.1 assistance or health care fraud. Regardless of imposition of sanctions, the commissioner
32.2 may make a referral to the appropriate state licensing board.

32.3 Sec. 33. Minnesota Statutes 2018, section 256B.064, subdivision 2, is amended to read:

32.4 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall
32.5 determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor
32.6 of medical care under this section. Except as provided in paragraphs (b) and (d), neither a
32.7 monetary recovery nor a sanction will be imposed by the commissioner without prior notice
32.8 and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed
32.9 action, provided that the commissioner may suspend or reduce payment to a vendor of
32.10 medical care, except a nursing home or convalescent care facility, after notice and prior to
32.11 the hearing if in the commissioner's opinion that action is necessary to protect the public
32.12 welfare and the interests of the program.

32.13 (b) Except when the commissioner finds good cause not to suspend payments under
32.14 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
32.15 withhold or reduce payments to a vendor of medical care without providing advance notice
32.16 of such withholding or reduction if either of the following occurs:

32.17 (1) the vendor is convicted of a crime involving the conduct described in subdivision
32.18 1a; or

32.19 (2) the commissioner determines there is a credible allegation of fraud for which an
32.20 investigation is pending under the program. A credible allegation of fraud is an allegation
32.21 which has been verified by the state, from any source, including but not limited to:

32.22 (i) fraud hotline complaints;

32.23 (ii) claims data mining; and

32.24 (iii) patterns identified through provider audits, civil false claims cases, and law
32.25 enforcement investigations.

32.26 Allegations are considered to be credible when they have an indicia of reliability and
32.27 the state agency has reviewed all allegations, facts, and evidence carefully and acts
32.28 judiciously on a case-by-case basis.

32.29 (c) The commissioner must send notice of the withholding or reduction of payments
32.30 under paragraph (b) within five days of taking such action unless requested in writing by a
32.31 law enforcement agency to temporarily withhold the notice. The notice must:

32.32 (1) state that payments are being withheld according to paragraph (b);

33.1 (2) set forth the general allegations as to the nature of the withholding action, but need
33.2 not disclose any specific information concerning an ongoing investigation;

33.3 (3) except in the case of a conviction for conduct described in subdivision 1a, state that
33.4 the withholding is for a temporary period and cite the circumstances under which withholding
33.5 will be terminated;

33.6 (4) identify the types of claims to which the withholding applies; and

33.7 (5) inform the vendor of the right to submit written evidence for consideration by the
33.8 commissioner.

33.9 The withholding or reduction of payments will not continue after the commissioner
33.10 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
33.11 relating to the alleged fraud are completed, unless the commissioner has sent notice of
33.12 intention to impose monetary recovery or sanctions under paragraph (a). Upon conviction
33.13 for a crime related to the provision, management, or administration of a health service under
33.14 medical assistance, a payment held pursuant to this section by the commissioner or a managed
33.15 care organization that contracts with the commissioner under section 256B.035 is forfeited
33.16 to the commissioner or managed care organization, regardless of the amount charged in the
33.17 criminal complaint or the amount of criminal restitution ordered.

33.18 (d) The commissioner shall suspend or terminate a vendor's participation in the program
33.19 without providing advance notice and an opportunity for a hearing when the suspension or
33.20 termination is required because of the vendor's exclusion from participation in Medicare.
33.21 Within five days of taking such action, the commissioner must send notice of the suspension
33.22 or termination. The notice must:

33.23 (1) state that suspension or termination is the result of the vendor's exclusion from
33.24 Medicare;

33.25 (2) identify the effective date of the suspension or termination; and

33.26 (3) inform the vendor of the need to be reinstated to Medicare before reapplying for
33.27 participation in the program.

33.28 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is
33.29 to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision
33.30 3, by filing with the commissioner a written request of appeal. The appeal request must be
33.31 received by the commissioner no later than 30 days after the date the notification of monetary
33.32 recovery or sanction was mailed to the vendor. The appeal request must specify:

34.1 (1) each disputed item, the reason for the dispute, and an estimate of the dollar amount
 34.2 involved for each disputed item;

34.3 (2) the computation that the vendor believes is correct;

34.4 (3) the authority in statute or rule upon which the vendor relies for each disputed item;

34.5 (4) the name and address of the person or entity with whom contacts may be made
 34.6 regarding the appeal; and

34.7 (5) other information required by the commissioner.

34.8 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
 34.9 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
 34.10 commissioner may assess fines if specific required components of documentation are
 34.11 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
 34.12 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is
 34.13 less. If the commissioner determines that a vendor repeatedly violated this chapter or
 34.14 Minnesota Rules, chapter 9505, related to the provision of services to program recipients
 34.15 and the submission of claims for payment, the commissioner may order a vendor to forfeit
 34.16 a fine based on the nature, severity, and chronicity of the violations, in an amount of up to
 34.17 \$5,000 or 20 percent of the value of the claims, whichever is greater.

34.18 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
 34.19 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
 34.20 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
 34.21 commissioner issues a final order.

34.22 Sec. 34. Minnesota Statutes 2018, section 256B.064, is amended by adding a subdivision
 34.23 to read:

34.24 **Subd. 3. Vendor mandates on prohibited hiring.** (a) The commissioner shall maintain
 34.25 and publish a list of each excluded individual and entity that was convicted of a crime related
 34.26 to the provision, management, or administration of a medical assistance health service, or
 34.27 where participation in the program was suspended or terminated under subdivision 2. A
 34.28 vendor that receives funding from medical assistance shall not: (1) employ an individual
 34.29 or entity who is on the exclusion list; or (2) enter into or maintain a business relationship
 34.30 with an individual or entity that is on the exclusion list.

34.31 (b) Before hiring or entering into a business transaction, a vendor shall check the
 34.32 exclusion list. The vendor shall check the exclusion list on a monthly basis and document
 34.33 the date and time with a.m. and p.m. designations that the exclusion list was checked and

35.1 the name and title of the person who checked the exclusion list. The vendor shall: (1)
35.2 immediately terminate a current employee on the exclusion list; and (2) immediately
35.3 terminate a business relationship with an individual or entity on the exclusion list.

35.4 (c) A vendor's requirement to check the exclusion list and to terminate an employee on
35.5 the exclusion list applies to each employee, even if the named employee is not responsible
35.6 for direct patient care or direct submission of a claim to medical assistance. A vendor's
35.7 requirement to check the exclusion list and terminate a business relationship with an
35.8 individual or entity on the exclusion list applies to each business relationship, even if the
35.9 named individual or entity is not responsible for direct patient care or direct submission of
35.10 a claim to medical assistance.

35.11 (d) A vendor that employs or enters into or maintains a business relationship with an
35.12 individual or entity on the exclusion list shall refund any payment related to a service
35.13 rendered by an individual or entity on the exclusion list from the date the individual is
35.14 employed or the date the individual is placed on the exclusion list, whichever is later, and
35.15 a vendor may be subject to:

35.16 (1) sanctions under subdivision 2;

35.17 (2) a civil monetary penalty of up to \$25,000 for each determination by the department
35.18 that the vendor employed or contracted with an individual or entity on the exclusion list;
35.19 and

35.20 (3) other fines or penalties allowed by law.

35.21 **Sec. 35. [256B.0646] CORRECTIVE ACTIONS FOR PEOPLE USING PERSONAL**
35.22 **CARE ASSISTANCE SERVICES; MINNESOTA RESTRICTED RECIPIENT**
35.23 **PROGRAM.**

35.24 (a) When there is abusive or fraudulent billing of personal care assistance services or
35.25 community first services and supports under section 256B.85, the commissioner may place
35.26 a recipient in the Minnesota restricted recipient program as defined in Minnesota Rules,
35.27 part 9505.2165. A recipient placed in the Minnesota restricted recipient program under this
35.28 section must:

35.29 (1) use a designated traditional personal care assistance provider agency;

35.30 (2) obtain a new assessment as described in section 256B.0911, including consultation
35.31 with a registered or public health nurse on the long-term care consultation team under section
35.32 256B.0911, subdivision 3, paragraph (b), clause (2); and

36.1 (3) comply with additional conditions for the use of personal care assistance services or
 36.2 community first services and supports if the commissioner determines it is necessary to
 36.3 prevent future misuse of personal care assistance services or abusive or fraudulent billing
 36.4 related to personal care assistance services. These additional conditions may include, but
 36.5 are not limited to:

36.6 (i) the restriction of service authorizations to a duration of no more than one month; and

36.7 (ii) requiring a qualified professional to monitor and report services on a monthly basis.

36.8 (b) Placement in the Minnesota restricted recipient program under this section is subject
 36.9 to appeal according to section 256B.045.

36.10 Sec. 36. Minnesota Statutes 2018, section 256B.0651, subdivision 17, is amended to read:

36.11 Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each
 36.12 recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days
 36.13 prior to terminating services to a recipient, if the termination results from provider sanctions
 36.14 under section 256B.064, such as a payment withhold, a suspension of participation, or a
 36.15 termination of participation. If a home care provider determines it is unable to continue
 36.16 providing services to a recipient, the provider must notify the recipient, the recipient's
 36.17 responsible party, and the commissioner 30 days prior to terminating services to the recipient
 36.18 because of an action under section 256B.064, and must assist the commissioner and lead
 36.19 agency in supporting the recipient in transitioning to another home care provider of the
 36.20 recipient's choice.

36.21 (b) In the event of a payment withhold from a home care provider, a suspension of
 36.22 participation, or a termination of participation of a home care provider under section
 36.23 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care
 36.24 and the lead agencies for all recipients with active service agreements with the provider. At
 36.25 the commissioner's request, the lead agencies must contact recipients to ensure that the
 36.26 recipients are continuing to receive needed care, and that the recipients have been given
 36.27 free choice of provider if they transfer to another home care provider. In addition, the
 36.28 commissioner or the commissioner's delegate may directly notify recipients who receive
 36.29 care from the provider that payments have been or will be withheld or that the provider's
 36.30 participation in medical assistance has been or will be suspended or terminated, if the
 36.31 commissioner determines that notification is necessary to protect the welfare of the recipients.
 36.32 For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care
 36.33 organizations.

37.1 Sec. 37. Minnesota Statutes 2018, section 256B.0659, subdivision 3, is amended to read:

37.2 Subd. 3. ~~Nonecovered Personal care assistance services~~ not covered. (a) Personal care
37.3 assistance services are not eligible for medical assistance payment under this section when
37.4 provided:

37.5 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian,
37.6 licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or
37.7 responsible party;

37.8 (2) in order to meet staffing or license requirements in a residential or child care setting;

37.9 (3) solely as a child care or babysitting service; ~~or~~

37.10 (4) without authorization by the commissioner or the commissioner's designee; or

37.11 (5) on dates not within the frequency requirements of subdivision 14, paragraph (c), and
37.12 subdivision 19, paragraph (a).

37.13 (b) The following personal care services are not eligible for medical assistance payment
37.14 under this section when provided in residential settings:

37.15 (1) when the provider of home care services who is not related by blood, marriage, or
37.16 adoption owns or otherwise controls the living arrangement, including licensed or unlicensed
37.17 services; or

37.18 (2) when personal care assistance services are the responsibility of a residential or
37.19 program license holder under the terms of a service agreement and administrative rules.

37.20 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for
37.21 medical assistance reimbursement for personal care assistance services under this section
37.22 include:

37.23 (1) sterile procedures;

37.24 (2) injections of fluids and medications into veins, muscles, or skin;

37.25 (3) home maintenance or chore services;

37.26 (4) homemaker services not an integral part of assessed personal care assistance services
37.27 needed by a recipient;

37.28 (5) application of restraints or implementation of procedures under section 245.825;

37.29 (6) instrumental activities of daily living for children under the age of 18, except when
37.30 immediate attention is needed for health or hygiene reasons integral to the personal care
37.31 services and the need is listed in the service plan by the assessor; and

38.1 (7) assessments for personal care assistance services by personal care assistance provider
38.2 agencies or by independently enrolled registered nurses.

38.3 Sec. 38. Minnesota Statutes 2018, section 256B.0659, subdivision 12, is amended to read:

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

38.9 (b) The activity documentation must correspond to the personal care assistance care plan
38.10 and be reviewed by the qualified professional.

38.11 (c) The personal care assistant time sheet must be on a form approved by the
38.12 commissioner documenting time the personal care assistant provides services in the home.
38.13 The following criteria must be included in the time sheet:

38.14 (1) full name of personal care assistant and individual provider number;

38.15 (2) provider name and telephone numbers;

38.16 (3) full name of recipient and either the recipient's medical assistance identification
38.17 number or date of birth;

38.18 (4) consecutive dates, including month, day, and year, and arrival and departure times
38.19 with a.m. or p.m. notations;

38.20 (5) signatures of recipient or the responsible party;

38.21 (6) personal signature of the personal care assistant;

38.22 (7) any shared care provided, if applicable;

38.23 (8) a statement that it is a federal crime to provide false information on personal care
38.24 service billings for medical assistance payments; and

38.25 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

38.26 Sec. 39. Minnesota Statutes 2018, section 256B.0659, subdivision 13, is amended to read:

38.27 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must
38.28 work for a personal care assistance provider agency ~~and~~, meet the definition of qualified
38.29 professional under section 256B.0625, subdivision 19c, and enroll with the department as
38.30 a qualified professional after clearing a background study. Before a qualified professional

39.1 provides services, the personal care assistance provider agency must initiate a background
39.2 study on the qualified professional under chapter 245C, and the personal care assistance
39.3 provider agency must have received a notice from the commissioner that the qualified
39.4 professional:

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

39.6 (2) is disqualified, but the qualified professional has received a set aside of the
39.7 disqualification under section 245C.22.

39.8 (b) The qualified professional shall perform the duties of training, supervision, and
39.9 evaluation of the personal care assistance staff and evaluation of the effectiveness of personal
39.10 care assistance services. The qualified professional shall:

39.11 (1) develop and monitor with the recipient a personal care assistance care plan based on
39.12 the service plan and individualized needs of the recipient;

39.13 (2) develop and monitor with the recipient a monthly plan for the use of personal care
39.14 assistance services;

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

39.16 (4) provide training and ensure competency for the personal care assistant in the individual
39.17 needs of the recipient; and

39.18 (5) document all training, communication, evaluations, and needed actions to improve
39.19 performance of the personal care assistants.

39.20 (c) Effective July 1, 2011, the qualified professional shall complete the provider training
39.21 with basic information about the personal care assistance program approved by the
39.22 commissioner. Newly hired qualified professionals must complete the training within six
39.23 months of the date hired by a personal care assistance provider agency. Qualified
39.24 professionals who have completed the required training as a worker from a personal care
39.25 assistance provider agency do not need to repeat the required training if they are hired by
39.26 another agency, if they have completed the training within the last three years. The required
39.27 training must be available with meaningful access according to title VI of the Civil Rights
39.28 Act and federal regulations adopted under that law or any guidance from the United States
39.29 Health and Human Services Department. The required training must be available online or
39.30 by electronic remote connection. The required training must provide for competency testing
39.31 to demonstrate an understanding of the content without attending in-person training. A
39.32 qualified professional is allowed to be employed and is not subject to the training requirement
39.33 until the training is offered online or through remote electronic connection. A qualified

40.1 professional employed by a personal care assistance provider agency certified for
40.2 participation in Medicare as a home health agency is exempt from the training required in
40.3 this subdivision. When available, the qualified professional working for a Medicare-certified
40.4 home health agency must successfully complete the competency test. The commissioner
40.5 shall ensure there is a mechanism in place to verify the identity of persons completing the
40.6 competency testing electronically.

40.7 Sec. 40. Minnesota Statutes 2018, section 256B.0659, subdivision 14, is amended to read:

40.8 Subd. 14. **Qualified professional; duties.** (a) Effective January 1, ~~2010~~ 2020, all personal
40.9 care assistants must be supervised by a qualified professional who is enrolled as an individual
40.10 provider with the commissioner under section 256B.04, subdivision 21, paragraph (c).

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

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

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

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

40.19 (c) The qualified professional shall evaluate the personal care assistant within the first
40.20 14 days of starting to provide regularly scheduled services for a recipient, or sooner as
40.21 determined by the qualified professional, except for the personal care assistance choice
40.22 option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified
40.23 professional shall evaluate the personal care assistance services for a recipient through direct
40.24 observation of a personal care assistant's work. The qualified professional may conduct
40.25 additional training and evaluation visits, based upon the needs of the recipient and the
40.26 personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal
40.27 care assistance services provided to a recipient do not require direct observation of each
40.28 personal care assistant's work and shall occur:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42.3 (2) agency administrative activities;

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

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

42.7 (i) The qualified professional shall notify the commissioner on a form prescribed by the
42.8 commissioner, within 30 days of when a qualified professional is no longer employed by
42.9 or otherwise affiliated with the personal care assistance agency for whom the qualified
42.10 professional previously provided qualified professional services.

42.11 Sec. 41. Minnesota Statutes 2018, section 256B.0659, subdivision 19, is amended to read:

42.12 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under
42.13 personal care assistance choice, the recipient or responsible party shall:

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

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

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

42.21 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with the
42.22 qualified professional, who is required to visit the recipient at least every 180 days;

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

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

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

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

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

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

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

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

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

43.8 (1) be the employer of the personal care assistant and the qualified professional for
43.9 employment law and related regulations including, but not limited to, purchasing and
43.10 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,
43.11 and liability insurance, and submit any or all necessary documentation including, but not
43.12 limited to, workers' compensation ~~and~~₂ unemployment insurance, and labor market data
43.13 required under section 256B.4912, subdivision 1a;

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

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

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

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

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

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

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

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

43.29 Sec. 42. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

43.30 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
43.31 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of

44.1 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
44.2 a format determined by the commissioner, information and documentation that includes,
44.3 but is not limited to, the following:

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

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

44.12 (3) proof of fidelity bond coverage in the amount of \$20,000;

44.13 (4) proof of workers' compensation insurance coverage;

44.14 (5) proof of liability insurance;

44.15 (6) a description of the personal care assistance provider agency's organization identifying
44.16 the names of all owners, managing employees, staff, board of directors, and the affiliations
44.17 of the directors, owners, or staff to other service providers;

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

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

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

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

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

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

45.5 (10) documentation that the personal care assistance provider agency and staff have
45.6 successfully completed all the training required by this section;

45.7 (11) documentation of the agency's marketing practices;

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

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

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

45.22 (15) a copy of the personal care assistance provider agency's self-auditing policy and
45.23 other materials demonstrating the personal care assistance provider agency's internal program
45.24 integrity procedures.

45.25 (b) Personal care assistance provider agencies enrolling for the first time must also
45.26 provide, at the time of enrollment as a personal care assistance provider agency in a format
45.27 determined by the commissioner, information and documentation that includes proof of
45.28 sufficient initial operating capital to support the infrastructure necessary to allow for ongoing
45.29 compliance with the requirements of this section. Sufficient operating capital can be
45.30 demonstrated as follows:

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

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

46.1 (3) any other manner proscribed by the commissioner.

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

46.7 ~~(e)~~ (d) All personal care assistance provider agencies shall require all employees in
46.8 management and supervisory positions and owners of the agency who are active in the
46.9 day-to-day management and operations of the agency to complete mandatory training as
46.10 determined by the commissioner before enrollment of the agency as a provider. Employees
46.11 in management and supervisory positions and owners who are active in the day-to-day
46.12 operations of an agency who have completed the required training as an employee with a
46.13 personal care assistance provider agency do not need to repeat the required training if they
46.14 are hired by another agency, if they have completed the training within the past three years.
46.15 By September 1, 2010, the required training must be available with meaningful access
46.16 according to title VI of the Civil Rights Act and federal regulations adopted under that law
46.17 or any guidance from the United States Health and Human Services Department. The
46.18 required training must be available online or by electronic remote connection. The required
46.19 training must provide for competency testing. Personal care assistance provider agency
46.20 billing staff shall complete training about personal care assistance program financial
46.21 management. This training is effective July 1, 2009. Any personal care assistance provider
46.22 agency enrolled before that date shall, if it has not already, complete the provider training
46.23 within 18 months of July 1, 2009. Any new owners or employees in management and
46.24 supervisory positions involved in the day-to-day operations are required to complete
46.25 mandatory training as a requisite of working for the agency. Personal care assistance provider
46.26 agencies certified for participation in Medicare as home health agencies are exempt from
46.27 the training required in this subdivision. When available, Medicare-certified home health
46.28 agency owners, supervisors, or managers must successfully complete the competency test.

46.29 (e) All personal care assistance provider agencies must provide, at the time of revalidation
46.30 as a personal care assistance provider agency in a format determined by the commissioner,
46.31 information and documentation that includes, but is not limited to, the following:

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

46.34 (2) financial statements demonstrating compliance with paragraph (a), clause (13).

47.1 Sec. 43. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

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

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

47.9 (4) comply with background study requirements;

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

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

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

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

47.17 (9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent
47.18 of the revenue generated by the medical assistance rate for personal care assistance services
47.19 for employee personal care assistant wages and benefits. The revenue generated by the
47.20 qualified professional and the reasonable costs associated with the qualified professional
47.21 shall not be used in making this calculation;

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

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

47.25 (12) report suspected neglect and abuse to the common entry point according to section
47.26 256B.0651;

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

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

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

48.3 Sec. 44. Minnesota Statutes 2018, section 256B.27, subdivision 3, is amended to read:

48.4 Subd. 3. **Access to medical records.** The commissioner of human services, with the
48.5 written consent of the recipient, on file with the local welfare agency, shall be allowed
48.6 access to all personal medical records of medical assistance recipients solely for the purposes
48.7 of investigating whether or not: (a) a vendor of medical care has submitted a claim for
48.8 reimbursement, a cost report or a rate application which is duplicative, erroneous, or false
48.9 in whole or in part, or which results in the vendor obtaining greater compensation than the
48.10 vendor is legally entitled to; or (b) the medical care was medically necessary. ~~The vendor~~
48.11 ~~of medical care shall receive notification from the commissioner at least 24 hours before~~
48.12 ~~the commissioner gains access to such records.~~ When the commissioner is investigating a
48.13 suspected overpayment of Medicaid funds, only after first conferring with the department's
48.14 Office of Inspector General, and documenting the evidentiary basis for any decision to
48.15 demand immediate access to medical records, the commissioner must be given immediate
48.16 access without prior notice to the vendor's office during regular business hours and to
48.17 documentation and records related to services provided and submission of claims for services
48.18 provided. Denying the commissioner access to records is cause for the vendor's immediate
48.19 suspension of payment or termination according to section 256B.064. The determination
48.20 of provision of services not medically necessary shall be made by the commissioner.
48.21 Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject
48.22 to any civil or criminal liability for providing access to medical records to the commissioner
48.23 of human services pursuant to this section.

48.24 Sec. 45. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
48.25 to read:

48.26 Subd. 1a. **Annual labor market reporting.** (a) As determined by the commissioner, a
48.27 provider of home and community-based services for the elderly under sections 256B.0913
48.28 and 256B.0915, home and community-based services for people with developmental
48.29 disabilities under section 256B.092, and home and community-based services for people
48.30 with disabilities under section 256B.49 shall submit data to the commissioner on the
48.31 following:

48.32 (1) number of direct-care staff;

48.33 (2) wages of direct-care staff;

- 49.1 (3) hours worked by direct-care staff;
- 49.2 (4) overtime wages of direct-care staff;
- 49.3 (5) overtime hours worked by direct-care staff;
- 49.4 (6) benefits paid and accrued by direct-care staff;
- 49.5 (7) direct-care staff retention rates;
- 49.6 (8) direct-care staff job vacancies;
- 49.7 (9) amount of travel time paid;
- 49.8 (10) program vacancy rates; and
- 49.9 (11) other related data requested by the commissioner.
- 49.10 (b) The commissioner may adjust reporting requirements for a self-employed direct-care
49.11 staff.
- 49.12 (c) For the purposes of this subdivision, "direct-care staff" means employees, including
49.13 self-employed individuals and individuals directly employed by a participant in a
49.14 consumer-directed service delivery option, providing direct service provision to people
49.15 receiving services under this section. Direct-care staff does not include executive, managerial,
49.16 or administrative staff.
- 49.17 (d) This subdivision also applies to a provider of personal care assistance services under
49.18 section 256B.0625, subdivision 19a; community first services and supports under section
49.19 256B.85; nursing services and home health services under section 256B.0625, subdivision
49.20 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and
49.21 habilitation services for residents of intermediate care facilities for persons with
49.22 developmental disabilities under section 256B.501.
- 49.23 (e) This subdivision also applies to financial management services providers for
49.24 participants who directly employ direct-care staff through consumer support grants under
49.25 section 256.476; the personal care assistance choice program under section 256B.0657,
49.26 subdivisions 18 to 20; community first services and supports under section 256B.85; and
49.27 the consumer-directed community supports option available under the alternative care
49.28 program, the brain injury waiver, the community alternative care waiver, the community
49.29 alternatives for disabled individuals waiver, the developmental disabilities waiver, the
49.30 elderly waiver, and the Minnesota senior health option, except financial management services
49.31 providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

50.1 (f) The commissioner shall ensure that data submitted under this subdivision is not
50.2 duplicative of data submitted under any other section of this chapter or any other chapter.

50.3 (g) A provider shall submit the data annually on a date specified by the commissioner.
50.4 The commissioner shall give a provider at least 30 calendar days to submit the data. If a
50.5 provider fails to submit the requested data by the date specified by the commissioner, the
50.6 commissioner may delay medical assistance reimbursement until the requested data is
50.7 submitted.

50.8 (h) Individually identifiable data submitted to the commissioner in this section are
50.9 considered private data on an individual, as defined by section 13.02, subdivision 12.

50.10 (i) The commissioner shall analyze data annually for workforce assessments and how
50.11 the data impact service access.

50.12 **EFFECTIVE DATE.** This section is effective January 1, 2020.

50.13 Sec. 46. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
50.14 to read:

50.15 Subd. 11. **Home and community-based service billing requirements.** (a) A home and
50.16 community-based service is eligible for reimbursement if:

50.17 (1) it is a service provided as specified in a federally approved waiver plan, as authorized
50.18 under sections 256B.0913, 256B.0915, 256B.092, and 256B.49;

50.19 (2) if applicable, it is provided on days and times during the days and hours of operation
50.20 specified on any license that is required under chapter 245A or 245D; or

50.21 (3) the home and community-based service provider has met the documentation
50.22 requirements under section 256B.4912, subdivision 12, 13, 14, or 15.

50.23 A service that does not meet the criteria in this subdivision may be recovered by the
50.24 department according to section 256B.064 and Minnesota Rules, parts 9505.2160 to
50.25 9505.2245.

50.26 (b) The provider must maintain documentation that all individuals providing service
50.27 have attested to reviewing and understanding the following statement upon employment
50.28 and annually thereafter.

50.29 "It is a federal crime to provide materially false information on service billings for
50.30 medical assistance or services provided under a federally approved waiver plan, as authorized
50.31 under Minnesota Statutes, sections 256B.0913, 256B.0915, 256B.092, and 256B.49."

51.1 Sec. 47. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
51.2 to read:

51.3 Subd. 12. **Home and community-based service documentation requirements.** (a)
51.4 Documentation may be collected and maintained electronically or in paper form by providers,
51.5 but must be made available and produced upon the request of the commissioner.
51.6 Documentation of delivered services that comply with the electronic visit verification
51.7 requirements under Laws 2017, First Special Session chapter 6, article 3, section 49, satisfy
51.8 the requirements of this subdivision.

51.9 (b) Documentation of a delivered service must be in English and must be legible according
51.10 to the standard of a reasonable person.

51.11 (c) If the service is reimbursed at an hourly or specified minute-based rate, each
51.12 documentation of the provision of a service, unless otherwise specified, must include:

51.13 (1) the date the documentation occurred;

51.14 (2) the day, month, and year when the service was provided;

51.15 (3) the start and stop times with a.m. and p.m. designations, except for case management
51.16 services as defined under sections 256B.0913, subdivision 7, 256B.0915, subdivision 1a,
51.17 256B.092, subdivision 1a, and 256B.49, subdivision 13;

51.18 (4) the service name or description of the service provided; and

51.19 (5) the name, signature, and title, if any, of the provider of service. If the service is
51.20 provided by multiple staff members, the provider may designate a staff member responsible
51.21 for verifying services and completing the documentation required by this paragraph.

51.22 (d) If the service is reimbursed at a daily rate or does not meet the requirements of
51.23 subdivision 12, paragraph (c), each documentation of the provision of a service, unless
51.24 otherwise specified, must include:

51.25 (1) the date the documentation occurred;

51.26 (2) the day, month, and year when the service was provided;

51.27 (3) the service name or description of the service provided; and

51.28 (4) the name, signature, and title, if any, of the person providing the service. If the service
51.29 is provided by multiple staff, the provider may designate a staff person responsible for
51.30 verifying services and completing the documentation required by this paragraph.

52.1 Sec. 48. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
52.2 to read:

52.3 Subd. 13. **Waiver transportation documentation and billing requirements.** (a) A
52.4 waiver transportation service must meet the billing requirements under section 256B.4912,
52.5 subdivision 11, to be eligible for reimbursement and must:

52.6 (1) be a waiver transportation service that is not covered by medical transportation under
52.7 the Medicaid state plan; and

52.8 (2) be a waiver transportation service that is not included as a component of another
52.9 waiver service.

52.10 (b) A waiver transportation service provider must meet the documentation requirements
52.11 under section 256B.4912, subdivision 12, and must maintain:

52.12 (1) odometer and other records as provided in section 256B.0625, subdivision 17b,
52.13 paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle
52.14 and driver for a waiver transportation service that is billed directly by the mile, except if
52.15 the provider is a common carrier as defined by Minnesota Rules, part 9505.0315, subpart
52.16 1, item B, or a publicly operated transit system; and

52.17 (2) documentation demonstrating that a vehicle and a driver meets the standards
52.18 determined by the Department of Human Services on vehicle and driver qualifications as
52.19 described in section 256B.0625, subdivision 17, paragraph (c).

52.20 Sec. 49. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
52.21 to read:

52.22 Subd. 14. **Equipment and supply documentation requirements.** (a) An equipment
52.23 and supply services provider must meet the documentation requirements under section
52.24 256B.4912, subdivision 12, and must, for each documentation of the provision of a service,
52.25 include:

52.26 (1) the recipient's assessed need for the equipment or supply and the reason the equipment
52.27 or supply is not covered by the Medicaid state plan;

52.28 (2) the type and brand name of the equipment or supply delivered to or purchased by
52.29 the recipient, including whether the equipment or supply was rented or purchased;

52.30 (3) the quantity of the equipment or supplies delivered or purchased; and

52.31 (4) the cost of equipment or supplies if the amount paid for the service depends on the
52.32 cost.

53.1 (b) A provider must maintain a copy of the shipping invoice or a delivery service tracking
53.2 log or other documentation showing the date of delivery that proves the equipment or supply
53.3 was delivered to the recipient or a receipt if the equipment or supply was purchased by the
53.4 recipient.

53.5 Sec. 50. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
53.6 to read:

53.7 Subd. 15. **Adult day service documentation and billing requirements.** (a) A service
53.8 defined as "adult day care" under section 245A.02, subdivision 2a, and licensed under
53.9 Minnesota Rules, parts 9555.9600 to 9555.9730, must meet the documentation requirements
53.10 under section 256B.4912, subdivision 12, and must maintain documentation of:

53.11 (1) a needs assessment and current plan of care according to section 245A.143,
53.12 subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, if applicable, for each recipient;

53.13 (2) attendance records as specified under section 245A.14, subdivision 14, paragraph
53.14 (c); the date of attendance must be documented on the attendance record with the day,
53.15 month, and year; and the pickup and drop-off time must be noted on the attendance record
53.16 in hours and minutes with a.m. and p.m. designations;

53.17 (3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710,
53.18 subparts 1, items E and H, 3, 4, and 6, if applicable;

53.19 (4) the names and qualifications of the registered physical therapists, registered nurses,
53.20 and registered dietitians who provide services to the adult day care or nonresidential program;
53.21 and

53.22 (5) the location where the service was provided and, if the location is an alternate location
53.23 from the primary place of service, the address, or if an address is not available, a description
53.24 of both the origin and destination location, the length of time at the alternate location with
53.25 a.m. and p.m. designations, and a list of participants who went to the alternate location.

53.26 (b) A provider cannot exceed its licensed capacity; if licensed capacity is exceeded, all
53.27 Minnesota health care program payments for that date shall be recovered by the department.

53.28 **EFFECTIVE DATE.** This section is effective August 1, 2019.

54.1 Sec. 51. Minnesota Statutes 2018, section 256B.5014, is amended to read:

54.2 **256B.5014 FINANCIAL REPORTING REQUIREMENTS.**

54.3 **Subdivision 1. Financial reporting.** All facilities shall maintain financial records and
54.4 shall provide annual income and expense reports to the commissioner of human services
54.5 on a form prescribed by the commissioner no later than April 30 of each year in order to
54.6 receive medical assistance payments. The reports for the reporting year ending December
54.7 31 must include:

54.8 (1) salaries and related expenses, including program salaries, administrative salaries,
54.9 other salaries, payroll taxes, and fringe benefits;

54.10 (2) general operating expenses, including supplies, training, repairs, purchased services
54.11 and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working
54.12 capital interest;

54.13 (3) property related costs, including depreciation, capital debt interest, rent, and leases;
54.14 and

54.15 (4) total annual resident days.

54.16 **Subd. 2. Labor market reporting.** All intermediate care facilities shall comply with
54.17 the labor market reporting requirements described in section 256B.4912, subdivision 1a.

54.18 Sec. 52. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

54.19 **Subd. 10. Agency-provider and FMS provider qualifications and duties.** (a)
54.20 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
54.21 13a shall:

54.22 (1) enroll as a medical assistance Minnesota health care programs provider and meet all
54.23 applicable provider standards and requirements;

54.24 (2) demonstrate compliance with federal and state laws and policies for CFSS as
54.25 determined by the commissioner;

54.26 (3) comply with background study requirements under chapter 245C and maintain
54.27 documentation of background study requests and results;

54.28 (4) verify and maintain records of all services and expenditures by the participant,
54.29 including hours worked by support workers;

55.1 (5) not engage in any agency-initiated direct contact or marketing in person, by telephone,
 55.2 or other electronic means to potential participants, guardians, family members, or participants'
 55.3 representatives;

55.4 (6) directly provide services and not use a subcontractor or reporting agent;

55.5 (7) meet the financial requirements established by the commissioner for financial
 55.6 solvency;

55.7 (8) have never had a lead agency contract or provider agreement discontinued due to
 55.8 fraud, or have never had an owner, board member, or manager fail a state or FBI-based
 55.9 criminal background check while enrolled or seeking enrollment as a Minnesota health care
 55.10 programs provider; and

55.11 (9) have an office located in Minnesota.

55.12 (b) In conducting general duties, agency-providers and FMS providers shall:

55.13 (1) pay support workers based upon actual hours of services provided;

55.14 (2) pay for worker training and development services based upon actual hours of services
 55.15 provided or the unit cost of the training session purchased;

55.16 (3) withhold and pay all applicable federal and state payroll taxes;

55.17 (4) make arrangements and pay unemployment insurance, taxes, workers' compensation,
 55.18 liability insurance, and other benefits, if any;

55.19 (5) enter into a written agreement with the participant, participant's representative, or
 55.20 legal representative that assigns roles and responsibilities to be performed before services,
 55.21 supports, or goods are provided;

55.22 (6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

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

55.25 (8) comply with any data requests from the department consistent with the Minnesota
 55.26 Government Data Practices Act under chapter 13.

55.27 Sec. 53. Minnesota Statutes 2018, section 256D.024, subdivision 3, is amended to read:

55.28 Subd. 3. **Fleeing felons offenders.** An individual who is fleeing to avoid prosecution,
 55.29 or custody, or confinement after conviction for a crime ~~that is a felony~~ under the laws of
 55.30 the jurisdiction from which the individual flees, ~~or in the case of New Jersey, is a high~~
 55.31 ~~misdemeanor~~, is ineligible to receive benefits under this chapter.

56.1 Sec. 54. **[256D.0245] DRUG TESTING INFORMATION FROM PROBATION**
 56.2 **OFFICERS.**

56.3 The local probation agency shall regularly provide a list of probationers who tested
 56.4 positive for an illegal controlled substance to the local social services agency, specifically
 56.5 the welfare fraud division, for purposes of section 256D.024.

56.6 Sec. 55. Minnesota Statutes 2018, section 256D.0515, is amended to read:

56.7 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

56.8 All food stamp households must be determined eligible for the benefit discussed under
 56.9 section 256.029. Food stamp households must demonstrate that: (1) their gross income is
 56.10 equal to or less than 165 percent of the federal poverty guidelines for the same family size;
 56.11 and (2) they have financial resources, excluding vehicles, of less than \$100,000.

56.12 Sec. 56. Minnesota Statutes 2018, section 256D.0516, subdivision 2, is amended to read:

56.13 Subd. 2. **Food support reporting requirements.** The commissioner of human services
 56.14 shall implement simplified reporting as permitted under the Food Stamp Act of 1977, as
 56.15 amended, and the food stamp regulations in Code of Federal Regulations, title 7, part 273.
 56.16 Food support recipient households are required to report periodically ~~shall not be required~~
 56.17 ~~to report more often than one time~~ every six months, and must report any changes in income,
 56.18 assets, or employment that affects eligibility within ten days of the date the change occurs.
 56.19 This provision shall not apply to households receiving food benefits under the Minnesota
 56.20 family investment program waiver.

56.21 Sec. 57. Minnesota Statutes 2018, section 256J.08, subdivision 47, is amended to read:

56.22 Subd. 47. **Income.** "Income" means cash or in-kind benefit, whether earned or unearned,
 56.23 received by or available to an applicant or participant that is not property under section
 56.24 256P.02. An applicant must document that the property is not available to the applicant.

56.25 Sec. 58. Minnesota Statutes 2018, section 256J.21, subdivision 2, is amended to read:

56.26 Subd. 2. **Income exclusions.** The following must be excluded in determining a family's
 56.27 available income:

56.28 (1) payments for basic care, difficulty of care, and clothing allowances received for
 56.29 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
 56.30 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for

- 57.1 children under section 260C.4411 or chapter 256N, and payments received and used for
57.2 care and maintenance of a third-party beneficiary who is not a household member;
- 57.3 (2) reimbursements for employment training received through the Workforce Investment
57.4 Act of 1998, United States Code, title 20, chapter 73, section 9201;
- 57.5 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
57.6 services, jury duty, employment, or informal carpooling arrangements directly related to
57.7 employment;
- 57.8 (4) all educational assistance, except the county agency must count graduate student
57.9 teaching assistantships, fellowships, and other similar paid work as earned income and,
57.10 after allowing deductions for any unmet and necessary educational expenses, shall count
57.11 scholarships or grants awarded to graduate students that do not require teaching or research
57.12 as unearned income;
- 57.13 (5) loans, regardless of purpose, from public or private lending institutions, governmental
57.14 lending institutions, or governmental agencies;
- 57.15 (6) loans from private individuals, regardless of purpose, provided an applicant or
57.16 participant ~~documents that the lender expects repayment~~ provides documentation of the
57.17 source of the loan, dates, amount of the loan, and terms of repayment;
- 57.18 (7)(i) state income tax refunds; and
- 57.19 (ii) federal income tax refunds;
- 57.20 (8)(i) federal earned income credits;
- 57.21 (ii) Minnesota working family credits;
- 57.22 (iii) state homeowners and renters credits under chapter 290A; and
- 57.23 (iv) federal or state tax rebates;
- 57.24 (9) funds received for reimbursement, replacement, or rebate of personal or real property
57.25 when these payments are made by public agencies, awarded by a court, solicited through
57.26 public appeal, or made as a grant by a federal agency, state or local government, or disaster
57.27 assistance organizations, subsequent to a presidential declaration of disaster;
- 57.28 (10) the portion of an insurance settlement that is used to pay medical, funeral, and burial
57.29 expenses, or to repair or replace insured property;
- 57.30 (11) reimbursements for medical expenses that cannot be paid by medical assistance;

58.1 (12) payments by a vocational rehabilitation program administered by the state under
58.2 chapter 268A, except those payments that are for current living expenses;

58.3 (13) in-kind income, including any payments directly made by a third party to a provider
58.4 of goods and services. In-kind income does not include in-kind payments of living expenses;

58.5 (14) assistance payments to correct underpayments, but only for the month in which the
58.6 payment is received;

58.7 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;

58.8 (16) funeral and cemetery payments as provided by section 256.935;

58.9 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in a calendar
58.10 month;

58.11 (18) any form of energy assistance payment made through Public Law 97-35,
58.12 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
58.13 providers by other public and private agencies, and any form of credit or rebate payment
58.14 issued by energy providers;

58.15 (19) Supplemental Security Income (SSI), including retroactive SSI payments and other
58.16 income of an SSI recipient;

58.17 (20) Minnesota supplemental aid, including retroactive payments;

58.18 (21) proceeds from the sale of real or personal property;

58.19 (22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota
58.20 permanency demonstration title IV-E waiver payments;

58.21 (23) state-funded family subsidy program payments made under section 252.32 to help
58.22 families care for children with developmental disabilities, consumer support grant funds
58.23 under section 256.476, and resources and services for a disabled household member under
58.24 one of the home and community-based waiver services programs under chapter 256B;

58.25 (24) interest payments and dividends from property that is not excluded from and that
58.26 does not exceed the asset limit;

58.27 (25) rent rebates;

58.28 (26) income earned by a minor caregiver, minor child through age 6, or a minor child
58.29 who is at least a half-time student in an approved elementary or secondary education program;

58.30 (27) income earned by a caregiver under age 20 who is at least a half-time student in an
58.31 approved elementary or secondary education program;

- 59.1 (28) MFIP child care payments under section 119B.05;
- 59.2 (29) all other payments made through MFIP to support a caregiver's pursuit of greater
59.3 economic stability;
- 59.4 (30) income a participant receives related to shared living expenses;
- 59.5 (31) reverse mortgages;
- 59.6 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42,
59.7 chapter 13A, sections 1771 to 1790;
- 59.8 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
59.9 United States Code, title 42, chapter 13A, section 1786;
- 59.10 (34) benefits from the National School Lunch Act, United States Code, title 42, chapter
59.11 13, sections 1751 to 1769e;
- 59.12 (35) relocation assistance for displaced persons under the Uniform Relocation Assistance
59.13 and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter
59.14 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12,
59.15 chapter 13, sections 1701 to 1750jj;
- 59.16 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part
59.17 2, sections 2271 to 2322;
- 59.18 (37) war reparations payments to Japanese Americans and Aleuts under United States
59.19 Code, title 50, sections 1989 to 1989d;
- 59.20 (38) payments to veterans or their dependents as a result of legal settlements regarding
59.21 Agent Orange or other chemical exposure under Public Law 101-239, section 10405,
59.22 paragraph (a)(2)(E);
- 59.23 (39) income that is otherwise specifically excluded from MFIP consideration in federal
59.24 law, state law, or federal regulation;
- 59.25 (40) security and utility deposit refunds;
- 59.26 (41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124,
59.27 and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and
59.28 Mille Lacs reservations and payments to members of the White Earth Band, under United
59.29 States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

60.1 (42) all income of the minor parent's parents and stepparents when determining the grant
 60.2 for the minor parent in households that include a minor parent living with parents or
 60.3 stepparents on MFIP with other children;

60.4 (43) income of the minor parent's parents and stepparents equal to 200 percent of the
 60.5 federal poverty guideline for a family size not including the minor parent and the minor
 60.6 parent's child in households that include a minor parent living with parents or stepparents
 60.7 not on MFIP when determining the grant for the minor parent. The remainder of income is
 60.8 deemed as specified in section 256J.37, subdivision 1b;

60.9 (44) payments made to children eligible for relative custody assistance under section
 60.10 257.85;

60.11 (45) vendor payments for goods and services made on behalf of a client unless the client
 60.12 has the option of receiving the payment in cash;

60.13 (46) the principal portion of a contract for deed payment;

60.14 (47) cash payments to individuals enrolled for full-time service as a volunteer under
 60.15 AmeriCorps programs including AmeriCorps VISTA, AmeriCorps State, AmeriCorps
 60.16 National, and AmeriCorps NCCC;

60.17 (48) housing assistance grants under section 256J.35, paragraph (a); and

60.18 (49) child support payments of up to \$100 for an assistance unit with one child and up
 60.19 to \$200 for an assistance unit with two or more children.

60.20 Sec. 59. Minnesota Statutes 2018, section 256J.26, subdivision 3, is amended to read:

60.21 Subd. 3. **Fleeing felons offenders.** An individual who is fleeing to avoid prosecution,
 60.22 or custody, or confinement after conviction for a crime ~~that is a felony~~ under the laws of
 60.23 the jurisdiction from which the individual flees, ~~or in the case of New Jersey, is a high~~
 60.24 ~~misdemeanor~~, is disqualified from receiving MFIP.

60.25 Sec. 60. **[256J.265] DRUG TESTING INFORMATION FROM PROBATION**
 60.26 **OFFICERS.**

60.27 The local probation agency shall regularly provide a list of probationers who tested
 60.28 positive for an illegal controlled substance to the local social services agency, specifically
 60.29 the welfare fraud division, for purposes of section 256J.26.

61.1 Sec. 61. Minnesota Statutes 2018, section 256L.01, subdivision 5, is amended to read:

61.2 Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income,
61.3 as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's
61.4 current income, or if income fluctuates month to month, the income for the 12-month
61.5 eligibility period. Income includes amounts deposited into checking and savings accounts
61.6 for personal expenses including rent, mortgage, automobile-related expenses, utilities, and
61.7 food.

61.8 Sec. 62. Minnesota Statutes 2018, section 256P.04, subdivision 4, is amended to read:

61.9 Subd. 4. **Factors to be verified.** (a) The agency shall verify the following at application:

61.10 (1) identity of adults;

61.11 (2) age, if necessary to determine eligibility;

61.12 (3) immigration status;

61.13 (4) income;

61.14 (5) spousal support and child support payments made to persons outside the household;

61.15 (6) vehicles;

61.16 (7) checking and savings accounts; Verification of checking and savings accounts must
61.17 include the source of deposits into accounts; identification of any loans, including the date,
61.18 source, amount, and terms of repayment; identification of deposits for personal expenses
61.19 including rent, mortgage, automobile-related expenses, utilities, and food;

61.20 (8) inconsistent information, if related to eligibility;

61.21 (9) residence;

61.22 (10) Social Security number; ~~and~~

61.23 (11) use of nonrecurring income under section 256P.06, subdivision 3, clause (2), item
61.24 (ix), for the intended purpose for which it was given and received;

61.25 (12) loans. Verification of loans must include the source, the full amount, and repayment
61.26 terms; and

61.27 (13) direct or indirect gifts of money.

61.28 (b) Applicants who are qualified noncitizens and victims of domestic violence as defined
61.29 under section 256J.08, subdivision 73, clause (7), are not required to verify the information
61.30 in paragraph (a), clause (10). When a Social Security number is not provided to the agency

62.1 for verification, this requirement is satisfied when each member of the assistance unit
62.2 cooperates with the procedures for verification of Social Security numbers, issuance of
62.3 duplicate cards, and issuance of new numbers which have been established jointly between
62.4 the Social Security Administration and the commissioner.

62.5 Sec. 63. Minnesota Statutes 2018, section 256P.06, subdivision 3, is amended to read:

62.6 Subd. 3. **Income inclusions.** The following must be included in determining the income
62.7 of an assistance unit:

62.8 (1) earned income:

62.9 (i) calculated according to Minnesota Rules, part 3400.0170, subpart 7, for earned income
62.10 from self-employment, except if the participant is drawing a salary, taking a draw from the
62.11 business, or using the business account to pay personal expenses including rent, mortgage,
62.12 automobile-related expenses, utilities, or food, not directly related to the business, the salary
62.13 or payment must be treated as earned income; and

62.14 (ii) excluding expenses listed in Minnesota Rules, part 3400.0170, subpart 8, items A
62.15 to I and M to P; and

62.16 (2) unearned income, which includes:

62.17 (i) interest and dividends from investments and savings;

62.18 (ii) capital gains as defined by the Internal Revenue Service from any sale of real property;

62.19 (iii) proceeds from rent and contract for deed payments in excess of the principal and
62.20 interest portion owed on property;

62.21 (iv) income from trusts, excluding special needs and supplemental needs trusts;

62.22 (v) interest income from loans made by the participant or household;

62.23 (vi) cash prizes and winnings;

62.24 (vii) unemployment insurance income;

62.25 (viii) retirement, survivors, and disability insurance payments;

62.26 (ix) nonrecurring income over \$60 per quarter unless earmarked and used for the purpose
62.27 for which it is intended. Income and use of this income is subject to verification requirements
62.28 under section 256P.04;

62.29 (x) retirement benefits;

63.1 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I,
63.2 and 256J;

63.3 (xii) tribal per capita payments unless excluded by federal and state law;

63.4 (xiii) income and payments from service and rehabilitation programs that meet or exceed
63.5 the state's minimum wage rate;

63.6 (xiv) income from members of the United States armed forces unless excluded from
63.7 income taxes according to federal or state law;

63.8 (xv) all child support payments for programs under chapters 119B, 256D, and 256I;

63.9 (xvi) the amount of child support received that exceeds \$100 for assistance units with
63.10 one child and \$200 for assistance units with two or more children for programs under chapter
63.11 256J; and

63.12 (xvii) spousal support.

63.13 Sec. 64. Laws 2017, First Special Session chapter 6, article 3, section 49, is amended to
63.14 read:

63.15 Sec. 49. ~~ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM~~
63.16 VISIT VERIFICATION.

63.17 Subdivision 1. **Documentation; establishment.** The commissioner of human services
63.18 shall establish implementation requirements and standards for an electronic ~~service delivery~~
63.19 ~~documentation system~~ visit verification to comply with the 21st Century Cures Act, Public
63.20 Law 114-255. Within available appropriations, the commissioner shall take steps to comply
63.21 with the electronic visit verification requirements in the 21st Century Cures Act, Public
63.22 Law 114-255.

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

63.25 (b) "Electronic ~~service delivery documentation~~ visit verification" means the electronic
63.26 documentation of the:

63.27 (1) type of service performed;

63.28 (2) individual receiving the service;

63.29 (3) date of the service;

63.30 (4) location of the service delivery;

64.1 (5) individual providing the service; and

64.2 (6) time the service begins and ends.

64.3 (c) "~~Electronic service delivery documentation~~ visit verification system" means a system
64.4 that provides ~~electronic service delivery documentation~~ verification of services that complies
64.5 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
64.6 3.

64.7 (d) "Service" means one of the following:

64.8 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
64.9 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; ~~or~~

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

64.11 (3) home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;
64.12 or

64.13 (4) other medical supplies and equipment or home and community-based services that
64.14 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

64.15 Subd. 3. **System requirements.** (a) In developing implementation requirements for ~~an~~
64.16 ~~electronic service delivery documentation system~~ visit verification, the commissioner shall
64.17 ~~consider electronic visit verification systems and other electronic service delivery~~
64.18 ~~documentation methods. The commissioner shall convene stakeholders that will be impacted~~
64.19 ~~by an electronic service delivery system, including service providers and their representatives,~~
64.20 ~~service recipients and their representatives, and, as appropriate, those with expertise in the~~
64.21 ~~development and operation of an electronic service delivery documentation system, to ensure~~
64.22 that the requirements:

64.23 (1) are minimally administratively and financially burdensome to a provider;

64.24 (2) are minimally burdensome to the service recipient and the least disruptive to the
64.25 service recipient in receiving and maintaining allowed services;

64.26 (3) consider existing best practices and use of ~~electronic service delivery documentation~~
64.27 visit verification;

64.28 (4) are conducted according to all state and federal laws;

64.29 (5) are effective methods for preventing fraud when balanced against the requirements
64.30 of clauses (1) and (2); and

65.1 (6) are consistent with the Department of Human Services' policies related to covered
65.2 services, flexibility of service use, and quality assurance.

65.3 (b) The commissioner shall make training available to providers on the electronic ~~service~~
65.4 ~~delivery documentation~~ visit verification system requirements.

65.5 (c) The commissioner shall establish baseline measurements related to preventing fraud
65.6 and establish measures to determine the effect of electronic ~~service-delivery documentation~~
65.7 visit verification requirements on program integrity.

65.8 (d) The commissioner shall make a state-selected electronic visit verification system
65.9 available to providers of services.

65.10 Subd. 3a. **Provider requirements.** (a) Providers of services may select their own
65.11 electronic visit verification system that meets the requirements established by the
65.12 commissioner.

65.13 (b) All electronic visit verification systems used by providers to comply with the
65.14 requirements established by the commissioner must provide data to the commissioner in a
65.15 format and at a frequency to be established by the commissioner.

65.16 (c) Providers must implement the electronic visit verification systems required under
65.17 this section by January 1, 2020, for personal care services and by January 1, 2023, for home
65.18 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
65.19 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
65.20 paragraph, "personal care services" and "home health services" have the meanings given
65.21 in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must
65.22 not be reduced as a result of federal action to reduce the federal medical assistance percentage
65.23 under the 21st Century Cures Act, Public Law 114.255, Code of Federal Regulations, title
65.24 32, section 310.32.

65.25 ~~Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,~~
65.26 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
65.27 ~~jurisdiction over human services with recommendations, based on the requirements of~~
65.28 ~~subdivision 3, to establish electronic service-delivery documentation system requirements~~
65.29 ~~and standards. The report shall identify:~~

65.30 ~~(1) the essential elements necessary to operationalize a base-level electronic service~~
65.31 ~~delivery documentation system to be implemented by January 1, 2019; and~~

66.1 ~~(2) enhancements to the base-level electronic service delivery documentation system to~~
 66.2 ~~be implemented by January 1, 2019, or after, with projected operational costs and the costs~~
 66.3 ~~and benefits for system enhancements.~~

66.4 ~~(b) The report must also identify current regulations on service providers that are either~~
 66.5 ~~inefficient, minimally effective, or will be unnecessary with the implementation of an~~
 66.6 ~~electronic service delivery documentation system.~~

66.7 Sec. 65. **DIRECTIONS TO COMMISSIONER; NEMT DRIVER ENROLLMENT**
 66.8 **IMPACT.**

66.9 By August 1, 2021, the commissioner of human services shall issue a report to the chairs
 66.10 and ranking minority members of the house of representatives and senate committees with
 66.11 jurisdiction over health and human services. The commissioner must include in the report
 66.12 the commissioner's findings regarding the impact of driver enrollment under Minnesota
 66.13 Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the
 66.14 nonemergency medical transportation program. The commissioner must include a
 66.15 recommendation, based on the findings in the report, regarding expanding the driver
 66.16 enrollment requirement.

66.17 Sec. 66. **UNIVERSAL IDENTIFICATION NUMBER FOR CHILDREN IN EARLY**
 66.18 **CHILDHOOD PROGRAMS.**

66.19 By July 1, 2020, the commissioners of the Departments of Education, Health, and Human
 66.20 Services shall identify a process to establish and implement a universal identification number
 66.21 for children participating in early childhood programs to eliminate potential duplication in
 66.22 programs. The commissioners shall report the identified process and any associated fiscal
 66.23 cost to the chairs and ranking minority members of the legislative committees with
 66.24 jurisdiction over health, human services, and education. A universal identification number
 66.25 established and implemented under this section is private data on individuals, as defined in
 66.26 Minnesota Statutes, section 13.02, subdivision 12, except that the commissioners of
 66.27 education, health, and human services may share the universal identification number with
 66.28 each other pursuant to their data sharing authority under Minnesota Statutes, section 13.46,
 66.29 subdivision 2, clause (9), and Minnesota Statutes, section 145A.17, subdivision 3, paragraph
 66.30 (e).

67.1 **Sec. 67. DIRECTION TO COMMISSIONER; FEDERAL WAIVER FOR MEDICAL**
 67.2 **ASSISTANCE SELF-ATTESTATION REMOVAL.**

67.3 The commissioner of human services shall seek all necessary federal waivers to
 67.4 implement the removal of the self-attestation when establishing eligibility for medical
 67.5 assistance.

67.6 **Sec. 68. REVISOR'S INSTRUCTION.**

67.7 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
 67.8 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.

67.9 **Sec. 69. REPEALER.**

67.10 Minnesota Statutes 2018, section 256B.0705, is repealed.

67.11 **EFFECTIVE DATE.** This section is effective January 1, 2020.

67.12 **ARTICLE 2**

67.13 **CHILDREN AND FAMILIES SERVICES**

67.14 Section 1. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

67.15 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
 67.16 not including a child determined eligible for medical assistance without consideration of
 67.17 parental income under the TEFRA option or for the purposes of accessing home and
 67.18 community-based waiver services, must contribute to the cost of services used by making
 67.19 monthly payments on a sliding scale based on income, unless the child is married or has
 67.20 been married, parental rights have been terminated, or the child's adoption is subsidized
 67.21 according to chapter 259A or through title IV-E of the Social Security Act. The parental
 67.22 contribution is a partial or full payment for medical services provided for diagnostic,
 67.23 therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care
 67.24 services as defined in United States Code, title 26, section 213, needed by the child with a
 67.25 chronic illness or disability.

67.26 (b) For households with adjusted gross income equal to or greater than 275 percent of
 67.27 federal poverty guidelines, the parental contribution shall be computed by applying the
 67.28 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

67.29 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
 67.30 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
 67.31 contribution shall be determined using a sliding fee scale established by the commissioner

68.1 of human services which begins at 1.94 percent of adjusted gross income at 275 percent of
68.2 federal poverty guidelines and increases to 5.29 percent of adjusted gross income for those
68.3 with adjusted gross income up to 545 percent of federal poverty guidelines;

68.4 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
68.5 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
68.6 5.29 percent of adjusted gross income;

68.7 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
68.8 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
68.9 shall be determined using a sliding fee scale established by the commissioner of human
68.10 services which begins at 5.29 percent of adjusted gross income at 675 percent of federal
68.11 poverty guidelines and increases to 7.05 percent of adjusted gross income for those with
68.12 adjusted gross income up to 975 percent of federal poverty guidelines; and

68.13 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
68.14 guidelines, the parental contribution shall be 8.81 percent of adjusted gross income.

68.15 If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400
68.16 prior to calculating the parental contribution. If the child resides in an institution specified
68.17 in section 256B.35, the parent is responsible for the personal needs allowance specified
68.18 under that section in addition to the parental contribution determined under this section.
68.19 The parental contribution is reduced by any amount required to be paid directly to the child
68.20 pursuant to a court order, but only if actually paid.

68.21 (c) The household size to be used in determining the amount of contribution under
68.22 paragraph (b) includes natural and adoptive parents and their dependents, including the
68.23 child receiving services. Adjustments in the contribution amount due to annual changes in
68.24 the federal poverty guidelines shall be implemented on the first day of July following
68.25 publication of the changes.

68.26 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
68.27 natural or adoptive parents determined according to the previous year's federal tax form,
68.28 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
68.29 have been used to purchase a home shall not be counted as income.

68.30 (e) The contribution shall be explained in writing to the parents at the time eligibility
68.31 for services is being determined. The contribution shall be made on a monthly basis effective
68.32 with the first month in which the child receives services. Annually upon redetermination
68.33 or at termination of eligibility, if the contribution exceeded the cost of services provided,
68.34 the local agency or the state shall reimburse that excess amount to the parents, either by

69.1 direct reimbursement if the parent is no longer required to pay a contribution, or by a
69.2 reduction in or waiver of parental fees until the excess amount is exhausted. All
69.3 reimbursements must include a notice that the amount reimbursed may be taxable income
69.4 if the parent paid for the parent's fees through an employer's health care flexible spending
69.5 account under the Internal Revenue Code, section 125, and that the parent is responsible
69.6 for paying the taxes owed on the amount reimbursed.

69.7 (f) The monthly contribution amount must be reviewed at least every 12 months; when
69.8 there is a change in household size; and when there is a loss of or gain in income from one
69.9 month to another in excess of ten percent. The local agency shall mail a written notice 30
69.10 days in advance of the effective date of a change in the contribution amount. A decrease in
69.11 the contribution amount is effective in the month that the parent verifies a reduction in
69.12 income or change in household size.

69.13 (g) Parents of a minor child who do not live with each other shall each pay the
69.14 contribution required under paragraph (a). An amount equal to the annual court-ordered
69.15 child support payment actually paid on behalf of the child receiving services shall be deducted
69.16 from the adjusted gross income of the parent making the payment prior to calculating the
69.17 parental contribution under paragraph (b).

69.18 (h) The contribution under paragraph (b) shall be increased by an additional five percent
69.19 if the local agency determines that insurance coverage is available but not obtained for the
69.20 child. For purposes of this section, "available" means the insurance is a benefit of employment
69.21 for a family member at an annual cost of no more than five percent of the family's annual
69.22 income. For purposes of this section, "insurance" means health and accident insurance
69.23 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
69.24 self-insured plan, or preferred provider organization.

69.25 Parents who have more than one child receiving services shall not be required to pay
69.26 more than the amount for the child with the highest expenditures. There shall be no resource
69.27 contribution from the parents. The parent shall not be required to pay a contribution in
69.28 excess of the cost of the services provided to the child, not counting payments made to
69.29 school districts for education-related services. Notice of an increase in fee payment must
69.30 be given at least 30 days before the increased fee is due.

69.31 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in
69.32 the 12 months prior to July 1:

69.33 (1) the parent applied for insurance for the child;

69.34 (2) the insurer denied insurance;

70.1 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
 70.2 complaint or appeal, in writing, to the commissioner of health or the commissioner of
 70.3 commerce, or litigated the complaint or appeal; and

70.4 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

70.5 For purposes of this section, "insurance" has the meaning given in paragraph (h).

70.6 A parent who has requested a reduction in the contribution amount under this paragraph
 70.7 shall submit proof in the form and manner prescribed by the commissioner or county agency,
 70.8 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
 70.9 of the parents, court documents, and the written response of the insurer approving insurance.
 70.10 The determinations of the commissioner or county agency under this paragraph are not rules
 70.11 subject to chapter 14.

70.12 Sec. 2. [256.4751] PARENT-TO-PARENT PEER SUPPORT GRANTS.

70.13 (a) The commissioner shall make available grants to organizations to support
 70.14 parent-to-parent peer support programs that provide information and emotional support for
 70.15 families of children and youth with special health care needs.

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

70.19 (c) Eligible organizations must have an established parent-to-parent program that:

70.20 (1) conducts outreach and support to parents or guardians of a child or youth with special
 70.21 health care needs;

70.22 (2) provides to parents and guardians information, tools, and training to support their
 70.23 child and to successfully navigate the health and human services systems;

70.24 (3) facilitates ongoing peer support for parents and guardians from trained volunteer
 70.25 support parents;

70.26 (4) has staff and volunteers located statewide; and

70.27 (5) is affiliated with and communicates regularly with other parent-to-parent programs
 70.28 and national organizations to ensure best practices are implemented.

70.29 (d) Grant recipients must use grant funds for the purposes in paragraph (c).

70.30 (e) Grant recipients must report to the commissioner of human services annually by
 70.31 January 15 on the services and programs funded by the appropriation. The report must

71.1 include measurable outcomes from the previous year, including the number of families
 71.2 served and the number of volunteer support parents trained.

71.3 Sec. 3. Minnesota Statutes 2018, section 256B.14, subdivision 2, is amended to read:

71.4 Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to
 71.5 determine the ability of responsible relatives to contribute partial or complete payment or
 71.6 repayment of medical assistance furnished to recipients for whom they are responsible. All
 71.7 medical assistance exclusions shall be allowed, and a resource limit of \$10,000 for
 71.8 nonexcluded resources shall be implemented. Above these limits, a contribution of one-third
 71.9 of the excess resources shall be required. These rules shall not require payment or repayment
 71.10 when payment would cause undue hardship to the responsible relative or that relative's
 71.11 immediate family. These rules shall ~~be consistent with the requirements of section 252.27~~
 71.12 ~~for~~ not apply to parents of children whose eligibility for medical assistance was determined
 71.13 without deeming of the parents' resources and income under the TEFRA option or for the
 71.14 purposes of accessing home and community-based waiver services. The county agency
 71.15 shall give the responsible relative notice of the amount of the payment or repayment. If the
 71.16 state agency or county agency finds that notice of the payment obligation was given to the
 71.17 responsible relative, but that the relative failed or refused to pay, a cause of action exists
 71.18 against the responsible relative for that portion of medical assistance granted after notice
 71.19 was given to the responsible relative, which the relative was determined to be able to pay.

71.20 The action may be brought by the state agency or the county agency in the county where
 71.21 assistance was granted, for the assistance, together with the costs of disbursements incurred
 71.22 due to the action.

71.23 In addition to granting the county or state agency a money judgment, the court may,
 71.24 upon a motion or order to show cause, order continuing contributions by a responsible
 71.25 relative found able to repay the county or state agency. The order shall be effective only
 71.26 for the period of time during which the recipient receives medical assistance from the county
 71.27 or state agency.

71.28 Sec. 4. Minnesota Statutes 2018, section 256M.41, subdivision 3, is amended to read:

71.29 Subd. 3. **Payments based on performance.** (a) The commissioner shall make payments
 71.30 under this section to each county ~~board on a calendar year basis in an amount determined~~
 71.31 ~~under paragraph (b)~~ on or before July 10 of each year.

71.32 ~~(b) Calendar year allocations under subdivision 1 shall be paid to counties in the following~~
 71.33 ~~manner:~~

72.1 ~~(1) 80 percent of the allocation as determined in subdivision 1 must be paid to counties~~
72.2 ~~on or before July 10 of each year;~~

72.3 ~~(2) ten percent of the allocation shall be withheld until the commissioner determines if~~
72.4 ~~the county has met the performance outcome threshold of 90 percent based on face-to-face~~
72.5 ~~contact with alleged child victims. In order to receive the performance allocation, the county~~
72.6 ~~child protection workers must have a timely face-to-face contact with at least 90 percent of~~
72.7 ~~all alleged child victims of screened-in maltreatment reports. The standard requires that~~
72.8 ~~each initial face-to-face contact occur consistent with timelines defined in section 626.556,~~
72.9 ~~subdivision 10, paragraph (i). The commissioner shall make threshold determinations in~~
72.10 ~~January of each year and payments to counties meeting the performance outcome threshold~~
72.11 ~~shall occur in February of each year. Any withheld funds from this appropriation for counties~~
72.12 ~~that do not meet this requirement shall be reallocated by the commissioner to those counties~~
72.13 ~~meeting the requirement; and~~

72.14 ~~(3) ten percent of the allocation shall be withheld until the commissioner determines~~
72.15 ~~that the county has met the performance outcome threshold of 90 percent based on~~
72.16 ~~face-to-face visits by the case manager. In order to receive the performance allocation, the~~
72.17 ~~total number of visits made by caseworkers on a monthly basis to children in foster care~~
72.18 ~~and children receiving child protection services while residing in their home must be at least~~
72.19 ~~90 percent of the total number of such visits that would occur if every child were visited~~
72.20 ~~once per month. The commissioner shall make such determinations in January of each year~~
72.21 ~~and payments to counties meeting the performance outcome threshold shall occur in February~~
72.22 ~~of each year. Any withheld funds from this appropriation for counties that do not meet this~~
72.23 ~~requirement shall be reallocated by the commissioner to those counties meeting the~~
72.24 ~~requirement. For 2015, the commissioner shall only apply the standard for monthly foster~~
72.25 ~~care visits.~~

72.26 ~~(c) The commissioner shall work with stakeholders and the Human Services Performance~~
72.27 ~~Council under section 402A.16 to develop recommendations for specific outcome measures~~
72.28 ~~that counties should meet in order to receive funds withheld under paragraph (b), and include~~
72.29 ~~in those recommendations a determination as to whether the performance measures under~~
72.30 ~~paragraph (b) should be modified or phased out. The commissioner shall report the~~
72.31 ~~recommendations to the legislative committees having jurisdiction over child protection~~
72.32 ~~issues by January 1, 2018.~~

73.1 Sec. 5. Minnesota Statutes 2018, section 256M.41, is amended by adding a subdivision
73.2 to read:

73.3 Subd. 4. **County performance on child protection measures.** The commissioner shall
73.4 set child protection measures and standards. The commissioner shall require an
73.5 underperforming county to demonstrate that the county designated sufficient funds and
73.6 implemented a reasonable strategy to improve child protection performance, including the
73.7 provision of a performance improvement plan and additional remedies identified by the
73.8 commissioner. The commissioner may redirect up to 20 percent of a county's funds under
73.9 this section toward the performance improvement plan. Sanctions under section 256M.20,
73.10 subdivision 3, related to noncompliance with federal performance standards also apply.

73.11 Sec. 6. [260C.216] FOSTER CARE RECRUITMENT GRANT PROGRAM.

73.12 Subdivision 1. **Establishment and authority.** The commissioner of human services
73.13 shall make grants to facilitate partnerships between counties and community groups or faith
73.14 communities to develop and utilize innovative, nontraditional shared recruitment methods
73.15 to increase and stabilize the number of available foster care families.

73.16 Subd. 2. **Eligibility.** An eligible applicant for a foster care recruitment grant under
73.17 subdivision 1 is an organization or entity that:

73.18 (1) provides a written description identifying the county and community organizations
73.19 or faith communities that will partner to develop innovative shared methods to recruit
73.20 families through their community or faith organizations for foster care in the county;

73.21 (2) agrees to incorporate efforts by the partnership or a third party to offer additional
73.22 support services including host families, family coaches, or resource referrals for families
73.23 in crisis such as homelessness, unemployment, hospitalization, substance abuse treatment,
73.24 incarceration, or domestic violence, as an alternative to foster care; and

73.25 (3) describes how the proposed partnership model can be generalized to be used in other
73.26 areas of the state.

73.27 Subd. 3. **Allowable grant activities.** Grant recipients may use grant funds to:

73.28 (1) develop materials that promote the partnership's innovative methods of nontraditional
73.29 recruitment of foster care families through the partner community organizations or faith
73.30 communities;

74.1 (2) develop an onboarding vehicle or training program for recruited foster care families
 74.2 that is accessible, relatable, and easy to understand, to be used by the partner community
 74.3 organizations or faith communities;

74.4 (3) establish sustainable communication between the partnership and the recruited
 74.5 families for ongoing support; or

74.6 (4) provide support services including host families, family coaches, or resource referrals
 74.7 for families in crisis such as homelessness, unemployment, hospitalization, substance abuse
 74.8 treatment, incarceration, or domestic violence, as an alternative to the foster care system.

74.9 Subd. 4. **Reporting** The commissioner shall report on the use of foster care recruitment
 74.10 grants to the chairs and ranking minority members of the legislative committees with
 74.11 jurisdiction over human services by December 31, 2020. The report shall include the name
 74.12 and location of grant recipients, the amount of each grant, the services provided, and the
 74.13 effects on the foster care system. The commissioner shall determine the form required for
 74.14 the report and may specify additional reporting requirements.

74.15 Subd. 5. **Funding.** The commissioner of human services may use available parent support
 74.16 outreach program funds for foster care recruitment grants under Minnesota Statutes, section
 74.17 260C.216.

74.18 **Sec. 7. [260C.218] PARENT SUPPORT FOR BETTER OUTCOMES GRANTS.**

74.19 The commissioner of human services may use available parent support outreach program
 74.20 funds to provide mentoring, guidance, and support services to parents navigating the child
 74.21 welfare system in Minnesota, in order to promote the development of safe, stable, and
 74.22 healthy families, including parent mentoring, peer-to-peer support groups, housing support
 74.23 services, training, staffing, and administrative costs.

74.24 **Sec. 8. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:**

74.25 **Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed****
 74.26 **on a less than full-time basis.** A parent is not considered voluntarily unemployed,
 74.27 underemployed, or employed on a less than full-time basis upon a showing by the parent
 74.28 that:

74.29 (1) the unemployment, underemployment, or employment on a less than full-time basis
 74.30 is temporary and will ultimately lead to an increase in income;

75.1 (2) the unemployment, underemployment, or employment on a less than full-time basis
 75.2 represents a bona fide career change that outweighs the adverse effect of that parent's
 75.3 diminished income on the child; or

75.4 (3) the unemployment, underemployment, or employment on a less than full-time basis
 75.5 is because a parent is physically or mentally incapacitated or due to incarceration, ~~except~~
 75.6 ~~where the reason for incarceration is the parent's nonpayment of support.~~

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

75.8 Sec. 9. Minnesota Statutes 2018, section 518A.51, is amended to read:

75.9 **518A.51 FEES FOR IV-D SERVICES.**

75.10 (a) When a recipient of IV-D services is no longer receiving assistance under the state's
 75.11 title IV-A, IV-E foster care, or medical assistance programs, the public authority responsible
 75.12 for child support enforcement must notify the recipient, within five working days of the
 75.13 notification of ineligibility, that IV-D services will be continued unless the public authority
 75.14 is notified to the contrary by the recipient. The notice must include the implications of
 75.15 continuing to receive IV-D services, including the available services and fees, cost recovery
 75.16 fees, and distribution policies relating to fees.

75.17 (b) In the case of an individual who has never received assistance under a state program
 75.18 funded under title IV-A of the Social Security Act and for whom the public authority has
 75.19 collected at least ~~\$500~~ \$550 of support, the public authority must impose an annual federal
 75.20 collections fee of ~~\$25~~ \$35 for each case in which services are furnished. This fee must be
 75.21 retained by the public authority from support collected on behalf of the individual, but not
 75.22 from the first ~~\$500~~ \$550 collected.

75.23 (c) When the public authority provides full IV-D services to an obligee who has applied
 75.24 for those services, upon written notice to the obligee, the public authority must charge a
 75.25 cost recovery fee of two percent of the amount collected. This fee must be deducted from
 75.26 the amount of the child support and maintenance collected and not assigned under section
 75.27 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

75.28 (1) is currently receiving assistance under the state's title IV-A, IV-E foster care, or
 75.29 medical assistance programs; or

75.30 (2) has received assistance under the state's title IV-A or IV-E foster care programs,
 75.31 until the person has not received this assistance for 24 consecutive months.

76.1 (d) When the public authority provides full IV-D services to an obligor who has applied
76.2 for such services, upon written notice to the obligor, the public authority must charge a cost
76.3 recovery fee of two percent of the monthly court-ordered child support and maintenance
76.4 obligation. The fee may be collected through income withholding, as well as by any other
76.5 enforcement remedy available to the public authority responsible for child support
76.6 enforcement.

76.7 (e) Fees assessed by state and federal tax agencies for collection of overdue support
76.8 owed to or on behalf of a person not receiving public assistance must be imposed on the
76.9 person for whom these services are provided. The public authority upon written notice to
76.10 the obligee shall assess a fee of \$25 to the person not receiving public assistance for each
76.11 successful federal tax interception. The fee must be withheld prior to the release of the funds
76.12 received from each interception and deposited in the general fund.

76.13 (f) Federal collections fees collected under paragraph (b) and cost recovery fees collected
76.14 under paragraphs (c) and (d) retained by the commissioner of human services shall be
76.15 considered child support program income according to Code of Federal Regulations, title
76.16 45, section 304.50, and shall be deposited in the special revenue fund account established
76.17 under paragraph (h). The commissioner of human services must elect to recover costs based
76.18 on either actual or standardized costs.

76.19 (g) The limitations of this section on the assessment of fees shall not apply to the extent
76.20 inconsistent with the requirements of federal law for receiving funds for the programs under
76.21 title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections
76.22 601 to 613 and United States Code, title 42, sections 651 to 662.

76.23 (h) The commissioner of human services is authorized to establish a special revenue
76.24 fund account to receive the federal collections fees collected under paragraph (b) and cost
76.25 recovery fees collected under paragraphs (c) and (d).

76.26 (i) The nonfederal share of the cost recovery fee revenue must be retained by the
76.27 commissioner and distributed as follows:

76.28 (1) one-half of the revenue must be transferred to the child support system special revenue
76.29 account to support the state's administration of the child support enforcement program and
76.30 its federally mandated automated system;

76.31 (2) an additional portion of the revenue must be transferred to the child support system
76.32 special revenue account for expenditures necessary to administer the fees; and

77.1 (3) the remaining portion of the revenue must be distributed to the counties to aid the
77.2 counties in funding their child support enforcement programs.

77.3 (j) The nonfederal share of the federal collections fees must be distributed to the counties
77.4 to aid them in funding their child support enforcement programs.

77.5 (k) The commissioner of human services shall distribute quarterly any of the funds
77.6 dedicated to the counties under paragraphs (i) and (j) using the methodology specified in
77.7 section 256.979, subdivision 11. The funds received by the counties must be reinvested in
77.8 the child support enforcement program and the counties must not reduce the funding of
77.9 their child support programs by the amount of the funding distributed.

77.10 **EFFECTIVE DATE.** This section is effective October 1, 2019.

77.11 Sec. 10. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA**
77.12 **OPTION IMPROVEMENT MEASURES.**

77.13 (a) The commissioner of human services shall, using existing appropriations, develop
77.14 content to be included on the MNsure website explaining the TEFRA option under medical
77.15 assistance for applicants who indicate during the application process that a child in the
77.16 family has a disability.

77.17 (b) The commissioner shall develop a cover letter explaining the TEFRA option under
77.18 medical assistance, as well as the application and renewal process, to be disseminated with
77.19 the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA
77.20 option. The commissioner shall provide the content and the form to the executive director
77.21 of MNsure for inclusion on the MNsure website. The commissioner shall also develop and
77.22 implement education and training for lead agency staff statewide to improve understanding
77.23 of the medical assistance-TEFRA enrollment and renewal processes and procedures.

77.24 (c) The commissioner shall convene a stakeholder group that shall consider improvements
77.25 to the TEFRA option enrollment and renewal processes, including but not limited to revisions
77.26 to, or the development of, application and renewal paperwork specific to the TEFRA option;
77.27 possible technology solutions; and county processes.

77.28 (d) The stakeholder group must include representatives from the Department of Human
77.29 Services Health Care Division, MNsure, representatives from at least two counties in the
77.30 metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota,
77.31 Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance,
77.32 the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders
77.33 as identified by the commissioner of human services.

78.1 (e) The stakeholder group shall submit a report of the group's recommended
78.2 improvements and any associated costs to the commissioner by December 31, 2020. The
78.3 group shall also provide copies of the report to each stakeholder group member. The
78.4 commissioner shall provide a copy of the report to the legislative committees with jurisdiction
78.5 over medical assistance.

78.6 Sec. 11. **MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT**
78.7 **PROJECT.**

78.8 Subdivision 1. **Authorization.** (a) The commissioner of human services shall develop
78.9 a pilot project that tests an alternative benefit delivery system for the distribution of public
78.10 assistance benefits. The commissioner shall work with Dakota County and Olmsted County
78.11 to develop the pilot project in accordance with this section. The commissioner shall apply
78.12 for any federal waivers necessary to implement the pilot project.

78.13 (b) Prior to authorizing the pilot project, Dakota and Olmsted Counties must provide
78.14 the following information to the commissioner:

78.15 (1) identification of any federal waivers required to implement the pilot project and a
78.16 timeline for obtaining the waivers;

78.17 (2) identification of data sharing requirements between the counties and the commissioner
78.18 to administer the pilot project and evaluate the outcome measures under subdivision 4,
78.19 including the technology systems that will be developed to administer the pilot project and
78.20 a description of the elements of the technology systems that will ensure the privacy of the
78.21 data of the participants and provide financial oversight and accountability for expended
78.22 funds;

78.23 (3) documentation that demonstrates receipt of private donations or grants totaling at
78.24 least \$2,800,000 per year for three years to support implementation of the pilot project;

78.25 (4) a complete plan for implementing the pilot project, including an assurance that each
78.26 participant's unified benefit amount is proportionate to and in no event exceeds the total
78.27 amount that the participant would have received by participating in the underlying programs
78.28 for which they are eligible upon entering the pilot project, information about the
78.29 administration of the unified benefit amount to ensure that the benefit is used by participants
78.30 for the services provided through the underlying programs included in the unified benefit,
78.31 an explanation of which funds will be issued directly to providers and which funds will be
78.32 available on an EBT card, and information about consequences and remedies for improper
78.33 use of the unified benefit;

79.1 (5) an evaluation plan developed in consultation with the commissioner of management
79.2 and budget to ensure that the pilot project includes an evaluation using an experimental or
79.3 quasi-experimental design and a formal evaluation of the results of the pilot project; and

79.4 (6) documentation that demonstrates the receipt of a formal commitment of grants or
79.5 contracts with the federal government to complete a comprehensive evaluation of the pilot
79.6 project.

79.7 (c) The commissioner may authorize the pilot project only after reviewing the information
79.8 submitted under paragraph (b) and issuing a formal written approval of the proposed project.

79.9 Subd. 2. **Pilot project goals.** The goals of the pilot project are to:

79.10 (1) reduce the historical separation among the state programs and systems affecting
79.11 families who may receive public assistance;

79.12 (2) eliminate, where possible, regulatory or program restrictions to allow a comprehensive
79.13 approach to meeting the needs of the families in the pilot project; and

79.14 (3) focus on prevention-oriented supports and interventions.

79.15 Subd. 3. **Pilot project participants.** The pilot project developed by the commissioner
79.16 must include requirements that participants:

79.17 (1) be 30 years of age or younger with a minimum of one child and income below 200
79.18 percent of federal poverty guidelines;

79.19 (2) voluntarily agree to participate in the pilot project;

79.20 (3) be informed of the right to voluntarily discontinue participation in the pilot project;

79.21 (4) be eligible for or receiving assistance under the Minnesota family investment program
79.22 under Minnesota Statutes, chapter 256J, and at least one of the following programs: (i) the
79.23 child care assistance program under Minnesota Statutes, chapter 119B; (ii) the diversionary
79.24 work program under Minnesota Statutes, section 256J.95; (iii) the supplemental nutrition
79.25 assistance program under Minnesota Statutes, chapter 256D; or (iv) state or federal housing
79.26 support;

79.27 (5) provide informed, written consent that the participant waives eligibility for the
79.28 programs included in the unified benefit set for the duration of their participation in the
79.29 pilot project;

79.30 (6) be enrolled in an education program that is focused on obtaining a career that will
79.31 result in a livable wage;

80.1 (7) receive as the unified benefit only an amount that is proportionate to and does not
 80.2 exceed the total value of the benefits the participant would be eligible to receive under the
 80.3 underlying programs upon entering the pilot project; and

80.4 (8) shall not have the unified benefit amount counted as income for child support or tax
 80.5 purposes.

80.6 Subd. 4. **Outcomes.** (a) The outcome measures for the pilot project must be developed
 80.7 in consultation with the commissioner of management and budget, and must include:

80.8 (1) improvement in the affordability, safety, and permanence of suitable housing;

80.9 (2) improvement in family functioning and stability, including the areas of behavioral
 80.10 health, incarceration, involvement with the child welfare system;

80.11 (3) improvement in education readiness and outcomes for parents and children from
 80.12 early childhood through high school, including reduction in absenteeism, preschool readiness
 80.13 scores, third grade reading competency, graduation, grade point average, and standardized
 80.14 test improvement;

80.15 (4) improvement in attachment to the workforce of one or both parents, including
 80.16 enhanced job stability; wage gains; career advancement; and progress in career preparation;
 80.17 and

80.18 (5) improvement in health care access and health outcomes for parents and children and
 80.19 other outcomes determined in consultation with the commissioner of human services and
 80.20 the commissioner of management and budget.

80.21 (b) Dakota and Olmsted Counties shall report on the progress and outcomes of the pilot
 80.22 project to the chairs and ranking minority members of the legislative committees with
 80.23 jurisdiction over human services by January 15 of each year that the pilot project operates,
 80.24 beginning January 15, 2021.

80.25 Sec. 12. **DIRECTION TO COMMISSIONER; CHILD CARE ASSISTANCE**
 80.26 **PROGRAM REDESIGN.**

80.27 (a) By January 15, 2020, the commissioner of human services shall, following
 80.28 consultation with families, providers, and county agencies, report to the chairs and ranking
 80.29 minority members of the legislative committees having jurisdiction over child care with a
 80.30 proposal, for implementation by July 1, 2020, that redesigns the child care assistance program
 80.31 to meet all applicable federal requirements, achieve at least the following objectives, and
 80.32 include at least the following features:

- 81.1 (1) eliminates fraud;
- 81.2 (2) eliminates program inefficiencies;
- 81.3 (3) eliminates barriers to families entering the program;
- 81.4 (4) improves accessibility to child care for families in greater Minnesota and in the
81.5 metropolitan area;
- 81.6 (5) improves the quality of available child care;
- 81.7 (6) eliminates assistance rate disparities between greater Minnesota and the metropolitan
81.8 area;
- 81.9 (7) ensures future access to assistance and child care for families in greater Minnesota
81.10 and in the metropolitan area;
- 81.11 (8) develops additional options for providers to complete required training including
81.12 through online or remote access;
- 81.13 (9) improves ease of provider access to required training and quality improvement
81.14 resources;
- 81.15 (10) reforms the Parent Aware program, including by removing barriers to participation
81.16 for family child care providers, by implementing a method for evaluating the quality and
81.17 effectiveness of four-star rated programs, and by incorporating licensing violations, sanctions,
81.18 or maltreatment determinations into the star-rating program standards;
- 81.19 (11) proposes legislation that codifies Parent Aware program standards;
- 81.20 (12) implements a licensing and inspection structure based on differential monitoring;
- 81.21 (13) amends licensing requirements that have led to closure of child care programs,
81.22 especially family child care programs;
- 81.23 (14) recommends business development and technical assistance resources to promote
81.24 provider recruitment and retention;
- 81.25 (15) allows for family child care licensing alternatives, including permitting multiple
81.26 family child care providers to operate in a commercial or other building other than the
81.27 providers' residences; and
- 81.28 (16) improves family child care licensing efficiencies, including by adding a variance
81.29 structure and updating child ratios.
- 81.30 (b) The commissioner shall seek all necessary federal waivers to implement the proposed
81.31 redesign described in paragraph (a), including to authorize use of existing federal funding.

82.1 Sec. 13. **APPROPRIATION; CHILD CARE ASSISTANCE PROGRAM REDESIGN.**

82.2 \$236,453,000 is appropriated in fiscal year 2022 from the general fund to the
 82.3 commissioner of human services for the redesigned child care assistance program. This is
 82.4 a onetime appropriation and is available until June 30, 2023.

82.5 Sec. 14. **REVISOR INSTRUCTION.**

82.6 The revisor of statutes, in consultation with the Department of Human Services, House
 82.7 Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the
 82.8 terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program"
 82.9 or "SNAP" in Minnesota Statutes when appropriate. The revisor may make technical and
 82.10 other necessary changes to sentence structure to preserve the meaning of the text.

82.11 Sec. 15. **REVISOR INSTRUCTION.**

82.12 The revisor of statutes shall remove the terms "child care assistance program," "basic
 82.13 sliding fee child care," and "MFIP child care," or similar terms wherever the terms appear
 82.14 in Minnesota Statutes. The revisor shall also make technical and other necessary changes
 82.15 to sentence structure to preserve the meaning of the text.

82.16 **EFFECTIVE DATE.** This section is effective July 1, 2020.

82.17 Sec. 16. **REPEALER.**

82.18 (a) Minnesota Statutes 2018, sections 119B.011, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,
 82.19 10a, 11, 12, 13, 13a, 14, 15, 16, 17, 18, 19, 19a, 19b, 20, 20a, 21, and 22; 119B.02; 119B.025,
 82.20 subdivisions 1, 2, 3, and 4; 119B.03, subdivisions 1, 2, 3, 4, 5, 6, 6a, 6b, 8, 9, and 10;
 82.21 119B.035; 119B.04; 119B.05, subdivisions 1, 4, and 5; 119B.06, subdivisions 1, 2, and 3;
 82.22 119B.08, subdivisions 1, 2, and 3; 119B.09, subdivisions 1, 3, 4, 4a, 5, 6, 7, 8, 9, 9a, 10,
 82.23 11, 12, and 13; 119B.095; 119B.097; 119B.10, subdivisions 1, 2, and 3; 119B.105; 119B.11,
 82.24 subdivisions 1, 2a, 3, and 4; 119B.12, subdivisions 1 and 2; 119B.125; 119B.13, subdivisions
 82.25 1, 1a, 3, 3a, 3b, 3c, 4, 5, 6, and 7; 119B.14; 119B.15; and 119B.16, are repealed effective
 82.26 July 1, 2020.

82.27 (b) Minnesota Rules, parts 3400.0010; 3400.0020, subparts 1, 4, 5, 8, 9a, 10a, 12, 17a,
 82.28 18, 18a, 20, 24, 25, 26, 28, 29a, 31b, 32b, 33, 34a, 35, 37, 38, 38a, 38b, 39, 40, 40a, and
 82.29 44; 3400.0030; 3400.0035; 3400.0040, subparts 1, 3, 4, 5, 5a, 6a, 6b, 6c, 7, 8, 9, 10, 11, 12,
 82.30 13, 14, 15, 15a, 17, and 18; 3400.0060, subparts 2, 4, 5, 6, 6a, 7, 8, 9, and 10; 3400.0080,
 82.31 subparts 1, 1a, 1b, and 8; 3400.0090, subparts 1, 2, 3, and 4; 3400.0100, subparts 2a, 2b,
 82.32 2c, and 5; 3400.0110, subparts 1, 1a, 2, 2a, 3, 4a, 7, 8, 9, 10, and 11; 3400.0120, subparts

83.1 1, 1a, 2, 2a, 3, and 5; 3400.0130, subparts 1, 1a, 2, 3, 3a, 3b, 5, 5a, and 7; 3400.0140, subparts
 83.2 1, 2, 4, 5, 6, 7, 8, 9, 9a, 10, and 14; 3400.0150; 3400.0170, subparts 1, 3, 4, 6a, 7, 8, 9, 10,
 83.3 and 11; 3400.0180; 3400.0183, subparts 1, 2, and 5; 3400.0185; 3400.0187, subparts 1, 2,
 83.4 3, 4, and 6; 3400.0200; 3400.0220; 3400.0230, subpart 3; and 3400.0235, subparts 1, 2, 3,
 83.5 4, 5, and 6, are repealed are effective July 1, 2020.

83.6 (c) Laws 2017, First Special Session chapter 6, article 7, section 34, is repealed effective
 83.7 July 1, 2019.

83.8 **ARTICLE 3**

83.9 **CHEMICAL AND MENTAL HEALTH**

83.10 Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision
 83.11 to read:

83.12 Subd. 11. **Mental health data sharing.** Section 641.15, subdivision 3a, governs the
 83.13 sharing of data on prisoners who may have a mental illness or need services with county
 83.14 social service agencies or welfare system personnel.

83.15 Sec. 2. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

83.16 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
 83.17 make grants from available appropriations to assist:

83.18 (1) counties;

83.19 (2) Indian tribes;

83.20 (3) children's collaboratives under section 124D.23 or 245.493; or

83.21 (4) mental health service providers.

83.22 (b) The following services are eligible for grants under this section:

83.23 (1) services to children with emotional disturbances as defined in section 245.4871,
 83.24 subdivision 15, and their families;

83.25 (2) transition services under section 245.4875, subdivision 8, for young adults under
 83.26 age 21 and their families;

83.27 (3) respite care services for children with severe emotional disturbances who are at risk
 83.28 of out-of-home placement, whether or not the child is receiving case management services;

83.29 (4) children's mental health crisis services;

83.30 (5) mental health services for people from cultural and ethnic minorities;

- 84.1 (6) children's mental health screening and follow-up diagnostic assessment and treatment;
- 84.2 (7) services to promote and develop the capacity of providers to use evidence-based
- 84.3 practices in providing children's mental health services;
- 84.4 (8) school-linked mental health services, including transportation for children receiving
- 84.5 school-linked mental health services when school is not in session;
- 84.6 (9) building evidence-based mental health intervention capacity for children birth to age
- 84.7 five;
- 84.8 (10) suicide prevention and counseling services that use text messaging statewide;
- 84.9 (11) mental health first aid training;
- 84.10 (12) training for parents, collaborative partners, and mental health providers on the
- 84.11 impact of adverse childhood experiences and trauma and development of an interactive
- 84.12 website to share information and strategies to promote resilience and prevent trauma;
- 84.13 (13) transition age services to develop or expand mental health treatment and supports
- 84.14 for adolescents and young adults 26 years of age or younger;
- 84.15 (14) early childhood mental health consultation;
- 84.16 (15) evidence-based interventions for youth at risk of developing or experiencing a first
- 84.17 episode of psychosis, and a public awareness campaign on the signs and symptoms of
- 84.18 psychosis;
- 84.19 (16) psychiatric consultation for primary care practitioners; ~~and~~
- 84.20 (17) providers to begin operations and meet program requirements when establishing a
- 84.21 new children's mental health program. These may be start-up grants; and
- 84.22 (18) promoting and developing a provider's capacity to deliver multigenerational mental
- 84.23 health treatment and services.
- 84.24 (c) Services under paragraph (b) must be designed to help each child to function and
- 84.25 remain with the child's family in the community and delivered consistent with the child's
- 84.26 treatment plan. Transition services to eligible young adults under this paragraph must be
- 84.27 designed to foster independent living in the community.

84.28 Sec. 3. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

84.29 Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human

84.30 services shall establish by rule criteria to be used in determining the appropriate level of

84.31 chemical dependency care for each recipient of public assistance seeking treatment for

85.1 substance misuse or substance use disorder. Upon federal approval of a comprehensive
85.2 assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding
85.3 the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of
85.4 comprehensive assessments under section 254B.05 may determine and approve the
85.5 appropriate level of substance use disorder treatment for a recipient of public assistance.
85.6 The process for determining an individual's financial eligibility for the consolidated chemical
85.7 dependency treatment fund or determining an individual's enrollment in or eligibility for a
85.8 publicly subsidized health plan is not affected by the individual's choice to access a
85.9 comprehensive assessment for placement.

85.10 (b) The commissioner shall develop and implement a utilization review process for
85.11 publicly funded treatment placements to monitor and review the clinical appropriateness
85.12 and timeliness of all publicly funded placements in treatment.

85.13 (c) If a screen result is positive for alcohol or substance misuse, a brief screening for
85.14 alcohol or substance use disorder that is provided to a recipient of public assistance within
85.15 a primary care clinic, hospital, or other medical setting or school setting establishes medical
85.16 necessity and approval for an initial set of substance use disorder services identified in
85.17 section 254B.05, subdivision 5. The initial set of services approved for a recipient whose
85.18 screen result is positive may include four hours of individual or group substance use disorder
85.19 treatment, two hours of substance use disorder treatment coordination, or two hours of
85.20 substance use disorder peer support services provided by a qualified individual according
85.21 to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be
85.22 approved for additional treatment services.

85.23 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
85.24 1, 2019. The commissioner of human services shall notify the revisor of statutes when
85.25 federal approval is obtained or denied.

85.26 Sec. 4. Minnesota Statutes 2018, section 254A.19, is amended by adding a subdivision to
85.27 read:

85.28 Subd. 5. **Assessment via telemedicine.** Notwithstanding Minnesota Rules, part
85.29 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via telemedicine.

85.30 Sec. 5. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

85.31 Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency
85.32 treatment appropriation shall be placed in a special revenue account. ~~The commissioner~~
85.33 ~~shall annually transfer funds from the chemical dependency fund to pay for operation of~~

86.1 ~~the drug and alcohol abuse normative evaluation system and to pay for all costs incurred~~
 86.2 ~~by adding two positions for licensing of chemical dependency treatment and rehabilitation~~
 86.3 ~~programs located in hospitals for which funds are not otherwise appropriated. The remainder~~
 86.4 ~~of the money in the special revenue account must be used according to the requirements in~~
 86.5 ~~this chapter.~~

86.6 **EFFECTIVE DATE.** This section is effective July 1, 2019.

86.7 Sec. 6. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

86.8 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
 86.9 dependency fund is limited to payments for services other than detoxification licensed under
 86.10 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
 86.11 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
 86.12 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
 86.13 services other than detoxification provided in another state that would be required to be
 86.14 licensed as a chemical dependency program if the program were in the state. Out of state
 86.15 vendors must also provide the commissioner with assurances that the program complies
 86.16 substantially with state licensing requirements and possesses all licenses and certifications
 86.17 required by the host state to provide chemical dependency treatment. Vendors receiving
 86.18 payments from the chemical dependency fund must not require co-payment from a recipient
 86.19 of benefits for services provided under this subdivision. The vendor is prohibited from using
 86.20 the client's public benefits to offset the cost of services paid under this section. The vendor
 86.21 shall not require the client to use public benefits for room or board costs. This includes but
 86.22 is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP
 86.23 benefits. Retention of SNAP benefits is a right of a client receiving services through the
 86.24 consolidated chemical dependency treatment fund or through state contracted managed care
 86.25 entities. Payment from the chemical dependency fund shall be made for necessary room
 86.26 and board costs provided by vendors ~~certified according to~~ meeting the criteria under section
 86.27 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health
 86.28 according to sections 144.50 to 144.56 to a client who is:

86.29 (1) determined to meet the criteria for placement in a residential chemical dependency
 86.30 treatment program according to rules adopted under section 254A.03, subdivision 3; and

86.31 (2) concurrently receiving a chemical dependency treatment service in a program licensed
 86.32 by the commissioner and reimbursed by the chemical dependency fund.

86.33 (b) A county may, from its own resources, provide chemical dependency services for
 86.34 which state payments are not made. A county may elect to use the same invoice procedures

87.1 and obtain the same state payment services as are used for chemical dependency services
 87.2 for which state payments are made under this section if county payments are made to the
 87.3 state in advance of state payments to vendors. When a county uses the state system for
 87.4 payment, the commissioner shall make monthly billings to the county using the most recent
 87.5 available information to determine the anticipated services for which payments will be made
 87.6 in the coming month. Adjustment of any overestimate or underestimate based on actual
 87.7 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
 87.8 month.

87.9 (c) The commissioner shall coordinate chemical dependency services and determine
 87.10 whether there is a need for any proposed expansion of chemical dependency treatment
 87.11 services. ~~The commissioner shall deny vendor certification to any provider that has not~~
 87.12 ~~received prior approval from the commissioner for the creation of new programs or the~~
 87.13 ~~expansion of existing program capacity. The commissioner shall consider the provider's~~
 87.14 ~~capacity to obtain clients from outside the state based on plans, agreements, and previous~~
 87.15 ~~utilization history, when determining the need for new treatment services~~ The commissioner
 87.16 may deny vendor certification to a provider if the commissioner determines that the services
 87.17 currently available in the local area are sufficient to meet local need and that the addition
 87.18 of new services would be detrimental to individuals seeking these services.

87.19 **EFFECTIVE DATE.** This section is effective July 1, 2019.

87.20 Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

87.21 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
 87.22 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
 87.23 of local money, pay the state for 22.95 percent of the cost of chemical dependency services,
 87.24 ~~including those~~ except that the county shall pay the state for ten percent of the nonfederal
 87.25 share of the cost of chemical dependency services provided to persons eligible for enrolled
 87.26 in medical assistance under chapter 256B, and ten percent of the cost of room and board
 87.27 services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may
 87.28 use the indigent hospitalization levy for treatment and hospital payments made under this
 87.29 section.

87.30 (b) 22.95 percent of any state collections from private or third-party pay, less 15 percent
 87.31 for the cost of payment and collections, must be distributed to the county that paid for a
 87.32 portion of the treatment under this section.

87.33 (c) ~~For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are~~
 87.34 ~~equal to 20.2 percent.~~

88.1 **EFFECTIVE DATE.** This section is effective July 1, 2019.

88.2 Sec. 8. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

88.3 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
88.4 Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under~~
88.5 ~~sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the
88.6 income standards of section 256B.056, subdivision 4, and are not enrolled in medical
88.7 assistance, are entitled to chemical dependency fund services. State money appropriated
88.8 for this paragraph must be placed in a separate account established for this purpose.

88.9 (b) Persons with dependent children who are determined to be in need of chemical
88.10 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
88.11 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
88.12 local agency to access needed treatment services. Treatment services must be appropriate
88.13 for the individual or family, which may include long-term care treatment or treatment in a
88.14 facility that allows the dependent children to stay in the treatment facility. The county shall
88.15 pay for out-of-home placement costs, if applicable.

88.16 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
88.17 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
88.18 (12).

88.19 **EFFECTIVE DATE.** This section is effective September 1, 2019.

88.20 Sec. 9. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

88.21 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
88.22 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

88.23 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
88.24 while residing in the facility and provide consequences for infractions of those rules;

88.25 (2) is determined to meet applicable health and safety requirements;

88.26 (3) is not a jail or prison;

88.27 (4) is not concurrently receiving funds under chapter 256I for the recipient;

88.28 (5) admits individuals who are 18 years of age or older;

88.29 (6) is registered as a board and lodging or lodging establishment according to section
88.30 157.17;

- 89.1 (7) has awake staff on site 24 hours per day;
- 89.2 (8) has staff who are at least 18 years of age and meet the requirements of section
89.3 245G.11, subdivision 1, paragraph (b);
- 89.4 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;
- 89.5 (10) meets the requirements of section 245G.08, subdivision 5, if administering
89.6 medications to clients;
- 89.7 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
89.8 fraternization and the mandatory reporting requirements of section 626.557;
- 89.9 (12) documents coordination with the treatment provider to ensure compliance with
89.10 section 254B.03, subdivision 2;
- 89.11 (13) protects client funds and ensures freedom from exploitation by meeting the
89.12 provisions of section 245A.04, subdivision 13;
- 89.13 (14) has a grievance procedure that meets the requirements of section 245G.15,
89.14 subdivision 2; and
- 89.15 (15) has sleeping and bathroom facilities for men and women separated by a door that
89.16 is locked, has an alarm, or is supervised by awake staff.
- 89.17 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
89.18 paragraph (a), clauses (5) to (15).
- 89.19 (c) Licensed programs providing intensive residential treatment services or residential
89.20 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
89.21 of room and board and are exempt from paragraph (a), clauses (6) to (15).

89.22 **EFFECTIVE DATE.** This section is effective September 1, 2019.

89.23 Sec. 10. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

89.24 Subdivision 1. **State collections.** The commissioner is responsible for all collections
89.25 from persons determined to be partially responsible for the cost of care of an eligible person
89.26 receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may
89.27 initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid
89.28 cost of care. The commissioner may collect all third-party payments for chemical dependency
89.29 services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance
89.30 and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit~~
89.31 ~~in a dedicated account a percentage of collections to pay for the cost of operating the chemical~~

90.1 ~~dependency consolidated treatment fund invoice processing and vendor payment system,~~
 90.2 ~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency
 90.3 fund.

90.4 **EFFECTIVE DATE.** This section is effective July 1, 2019.

90.5 Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

90.6 Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal~~
 90.7 ~~financial participation collections to a special revenue account.~~ The commissioner shall
 90.8 allocate 77.05 percent of patient payments and third-party payments to the special revenue
 90.9 account and 22.95 percent to the county financially responsible for the patient.

90.10 ~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account~~
 90.11 ~~shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility~~
 90.12 ~~shall be reduced from 22.95 percent to 20.2 percent.~~

90.13 **EFFECTIVE DATE.** This section is effective July 1, 2019.

90.14 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

90.15 Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical
 90.16 or remedial care licensed and recognized under state law unless otherwise prohibited by
 90.17 law, ~~except licensed chemical dependency treatment programs or primary treatment or~~
 90.18 ~~extended care treatment units in hospitals that are covered under chapter 254B.~~ The
 90.19 ~~commissioner shall include chemical dependency services in the state medical assistance~~
 90.20 ~~plan for federal reporting purposes, but payment must be made under chapter 254B.~~ The
 90.21 commissioner shall publish in the State Register a list of elective surgeries that require a
 90.22 second medical opinion before medical assistance reimbursement, and the criteria and
 90.23 standards for deciding whether an elective surgery should require a second medical opinion.
 90.24 The list and criteria and standards are not subject to the requirements of sections 14.01 to
 90.25 14.69.

90.26 **EFFECTIVE DATE.** This section is effective July 1, 2019.

90.27 Sec. 13. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 90.28 to read:

90.29 Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use
 90.30 disorder treatment services according to section 254B.05, subdivision 5, except for room
 90.31 and board.

91.1 **EFFECTIVE DATE.** This section is effective July 1, 2019.

91.2 Sec. 14. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

91.3 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical
91.4 assistance coverage of health home services for eligible individuals with chronic conditions
91.5 who select a designated provider as the individual's health home.

91.6 (b) The commissioner shall implement this section in compliance with the requirements
91.7 of the state option to provide health homes for enrollees with chronic conditions, as provided
91.8 under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703
91.9 and 3502. Terms used in this section have the meaning provided in that act.

91.10 (c) The commissioner shall establish health homes to serve populations with serious
91.11 mental illness who meet the eligibility requirements described under subdivision 2, ~~clause~~
91.12 ~~(4)~~. The health home services provided by health homes shall focus on both the behavioral
91.13 and the physical health of these populations.

91.14 Sec. 15. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

91.15 Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home
91.16 models in accordance with United States Code, title 42, section 1396w-4.

91.17 (b) An individual is eligible for health home services under this section if the individual
91.18 is eligible for medical assistance under this chapter and has at least:

91.19 ~~(1) two chronic conditions;~~

91.20 ~~(2) one chronic condition and is at risk of having a second chronic condition;~~

91.21 ~~(3) one serious and persistent mental health condition; or~~

91.22 ~~(4) a condition that meets the definition of mental illness as described in section 245.462,~~
91.23 ~~subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871,~~
91.24 ~~subdivision 15, clause (2); and has a current diagnostic assessment as defined in Minnesota~~
91.25 ~~Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health~~
91.26 ~~professional employed by or under contract with the behavioral health home. The~~
91.27 ~~commissioner shall establish criteria for determining continued eligibility.~~

91.28 Sec. 16. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

91.29 Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible
91.30 individual may choose any designated provider. The commissioner shall establish designated

92.1 providers to serve as health homes and provide the services described in subdivision 3 to
 92.2 individuals eligible under subdivision 2. The commissioner shall apply for grants as provided
 92.3 under section 3502 of the Patient Protection and Affordable Care Act to establish health
 92.4 homes and provide capitated payments to designated providers. For purposes of this section,
 92.5 "designated provider" means a provider, clinical practice or clinical group practice, rural
 92.6 clinic, community health center, community mental health center, or any other entity that
 92.7 is determined by the commissioner to be qualified to be a health home for eligible individuals.
 92.8 This determination must be based on documentation evidencing that the designated provider
 92.9 has the systems and infrastructure in place to provide health home services and satisfies the
 92.10 qualification standards established by the commissioner in consultation with stakeholders
 92.11 and approved by the Centers for Medicare and Medicaid Services.

92.12 ~~(b) The commissioner shall develop and implement certification standards for designated~~
 92.13 ~~providers under this subdivision.~~

92.14 Sec. 17. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 92.15 to read:

92.16 Subd. 9. **Discharge criteria.** (a) An individual may be discharged from behavioral health
 92.17 home services if:

92.18 (1) the behavioral health home services provider is unable to locate, contact, and engage
 92.19 the individual for a period of greater than three months after persistent efforts by the
 92.20 behavioral health home services provider; or

92.21 (2) the individual is unwilling to participate in behavioral health home services as
 92.22 demonstrated by the individual's refusal to meet with the behavioral health home services
 92.23 provider, or refusal to identify the individual's goals or the activities or support necessary
 92.24 to achieve the individual's health and wellness goals.

92.25 (b) Before discharge from behavioral health home services, the behavioral health home
 92.26 services provider must offer a face-to-face meeting with the individual, the individual's
 92.27 identified supports, and the behavioral health home services provider to discuss options
 92.28 available to the individual, including maintaining behavioral health home services.

92.29 Sec. 18. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 92.30 to read:

92.31 Subd. 10. **Behavioral health home services provider requirements.** A behavioral
 92.32 health home services provider must:

- 93.1 (1) be an enrolled Minnesota Health Care Programs provider;
- 93.2 (2) provide a medical assistance covered primary care or behavioral health service;
- 93.3 (3) utilize an electronic health record;
- 93.4 (4) utilize an electronic patient registry that contains data elements required by the
93.5 commissioner;
- 93.6 (5) demonstrate the organization's capacity to administer screenings approved by the
93.7 commissioner for substance use disorder or alcohol and tobacco use;
- 93.8 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
93.9 to the individual's screening results;
- 93.10 (7) have policies and procedures to track referrals to ensure that the referral met the
93.11 individual's needs;
- 93.12 (8) conduct a brief needs assessment when an individual begins receiving behavioral
93.13 health home services. The brief needs assessment must be completed with input from the
93.14 individual and the individual's identified supports. The brief needs assessment must address
93.15 the individual's immediate safety and transportation needs and potential barriers to
93.16 participating in behavioral health home services;
- 93.17 (9) conduct a health wellness assessment within 60 days after intake that contains all
93.18 required elements identified by the commissioner;
- 93.19 (10) conduct a health action plan that contains all required elements identified by the
93.20 commissioner within 90 days after intake and updated at least once every six months or
93.21 more frequently if significant changes to an individual's needs or goals occur;
- 93.22 (11) agree to cooperate and participate with the state's monitoring and evaluation of
93.23 behavioral health home services; and
- 93.24 (12) utilize the form approved by the commissioner to obtain the individual's written
93.25 consent to begin receiving behavioral health home services.

93.26 Sec. 19. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
93.27 to read:

93.28 Subd. 11. **Provider training and practice transformation requirements.** (a) The
93.29 behavioral health home services provider must ensure that all staff delivering behavioral
93.30 health home services receive adequate preservice and ongoing training including:

94.1 (1) training approved by the commissioner that describes the goals and principles of
94.2 behavioral health home services; and

94.3 (2) training on evidence-based practices to promote an individual's ability to successfully
94.4 engage with medical, behavioral health, and social services to reach the individual's health
94.5 and wellness goals.

94.6 (b) The behavioral health home services provider must ensure that staff are capable of
94.7 implementing culturally responsive services as determined by the individual's culture,
94.8 beliefs, values, and language as identified in the individual's health wellness assessment.

94.9 (c) The behavioral health home services provider must participate in the department's
94.10 practice transformation activities to support continued skill and competency development
94.11 in the provision of integrated medical, behavioral health, and social services.

94.12 Sec. 20. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
94.13 to read:

94.14 Subd. 12. **Staff qualifications.** (a) A behavioral health home services provider must
94.15 maintain staff with required professional qualifications appropriate to the setting.

94.16 (b) If behavioral health home services are offered in a mental health setting, the
94.17 integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice
94.18 Act, sections 148.171 to 148.285.

94.19 (c) If behavioral health home services are offered in a primary care setting, the integration
94.20 specialist must be a mental health professional as defined in section 245.462, subdivision
94.21 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

94.22 (d) If behavioral health home services are offered in either a primary care setting or
94.23 mental health setting, the systems navigator must be a mental health practitioner as defined
94.24 in section 245.462, subdivision 17, or a community health worker as defined in section
94.25 256B.0625, subdivision 49.

94.26 (e) If behavioral health home services are offered in either a primary care setting or
94.27 mental health setting, the qualified health home specialist must be one of the following:

94.28 (1) a peer support specialist as defined in section 256B.0615;

94.29 (2) a family peer support specialist as defined in section 256B.0616;

94.30 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
94.31 (g), or 245.4871, subdivision 4, paragraph (j);

- 95.1 (4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision
 95.2 5, clause (4);
- 95.3 (5) a community paramedic as defined in section 144E.28, subdivision 9;
- 95.4 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);
 95.5 or
- 95.6 (7) a community health worker as defined in section 256B.0625, subdivision 49.

95.7 Sec. 21. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 95.8 to read:

95.9 Subd. 13. **Service delivery standards.** (a) A behavioral health home services provider
 95.10 must meet the following service delivery standards:

95.11 (1) establish and maintain processes to support the coordination of an individual's primary
 95.12 care, behavioral health, and dental care;

95.13 (2) maintain a team-based model of care, including regular coordination and
 95.14 communication between behavioral health home services team members;

95.15 (3) use evidence-based practices that recognize and are tailored to the medical, social,
 95.16 economic, behavioral health, functional impairment, cultural, and environmental factors
 95.17 affecting the individual's health and health care choices;

95.18 (4) use person-centered planning practices to ensure the individual's health action plan
 95.19 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
 95.20 the individual and the individual's identified supports;

95.21 (5) use the patient registry to identify individuals and population subgroups requiring
 95.22 specific levels or types of care and provide or refer the individual to needed treatment,
 95.23 intervention, or service;

95.24 (6) utilize Department of Human Services Partner Portal to identify past and current
 95.25 treatment or services and to identify potential gaps in care;

95.26 (7) deliver services consistent with standards for frequency and face-to-face contact as
 95.27 required by the commissioner;

95.28 (8) ensure that all individuals receiving behavioral health home services have a diagnostic
 95.29 assessment completed within six months of when the individual begins receiving behavioral
 95.30 health home services;

95.31 (9) deliver services in locations and settings that meet the needs of the individual;

96.1 (10) provide a central point of contact to ensure that individuals and the individual's
96.2 identified supports can successfully navigate the array of services that impact the individual's
96.3 health and well-being;

96.4 (11) have capacity to assess an individual's readiness for change and the individual's
96.5 capacity to integrate new health care or community supports into the individual's life;

96.6 (12) offer or facilitate the provision of wellness and prevention education on
96.7 evidenced-based curriculums specific to the prevention and management of common chronic
96.8 conditions;

96.9 (13) help an individual set up and prepare for appointments, including accompanying
96.10 the individual to appointments as appropriate, and follow up with the individual after medical,
96.11 behavioral health, social service, or community support appointments;

96.12 (14) offer or facilitate the provision of health coaching related to chronic disease
96.13 management and how to navigate complex systems of care to the individual, the individual's
96.14 family, and identified supports;

96.15 (15) connect an individual, the individual's family, and identified supports to appropriate
96.16 support services that help the individual overcome access or service barriers, increase
96.17 self-sufficiency skills, and improve overall health;

96.18 (16) provide effective referrals and timely access to services; and

96.19 (17) establish a continuous quality improvement process for providing behavioral health
96.20 home services.

96.21 (b) The behavioral health home services provider must also create a plan, in partnership
96.22 with the individual and the individual's identified supports, to support the individual after
96.23 discharge from a hospital, residential treatment program, or other setting. The plan must
96.24 include protocols for:

96.25 (1) maintaining contact between the behavioral health home services team member and
96.26 the individual and the individual's identified supports during and after discharge;

96.27 (2) linking the individual to new resources as needed;

96.28 (3) reestablishing the individual's existing services and community and social supports;
96.29 and

96.30 (4) following up with appropriate entities to transfer or obtain the individual's service
96.31 records as necessary for continued care.

97.1 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
97.2 provider must:

97.3 (1) notify the behavioral health home services contact designated by the managed care
97.4 plan within 30 days of when the individual begins behavioral health home services; and

97.5 (2) adhere to the managed care plan communication and coordination requirements
97.6 described in the behavioral health home services manual.

97.7 (d) Before terminating behavioral health home services, the behavioral health home
97.8 services provider must:

97.9 (1) provide a 60-day notice of termination of behavioral health home services to all
97.10 individuals receiving behavioral health home services, the department, and managed care
97.11 plans, if applicable; and

97.12 (2) refer individuals receiving behavioral health home services to a new behavioral
97.13 health home services provider.

97.14 Sec. 22. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
97.15 to read:

97.16 Subd. 14. **Provider variances.** (a) The commissioner may grant a variance to specific
97.17 requirements under subdivision 10, 11, 12, or 13 for a behavioral health home services
97.18 provider according to this subdivision.

97.19 (b) The commissioner may grant a variance if the commissioner finds that (1) failure to
97.20 grant the variance would result in hardship or injustice to the applicant, (2) the variance
97.21 would be consistent with the public interest, and (3) the variance would not reduce the level
97.22 of services provided to individuals served by the organization.

97.23 (c) The commissioner may grant a variance from one or more requirements to permit
97.24 an applicant to offer behavioral health home services of a type or in a manner that is
97.25 innovative if the commissioner finds that the variance does not impede the achievement of
97.26 the criteria in subdivision 10, 11, 12, or 13 and may improve the behavioral health home
97.27 services provided by the applicant.

97.28 (d) The commissioner's decision to grant or deny a variance request is final and not
97.29 subject to appeal.

98.1 Sec. 23. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

98.2 Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical
98.3 assistance demonstration project to test reforms of Minnesota's substance use disorder
98.4 treatment system to ensure individuals with substance use disorders have access to a full
98.5 continuum of high quality care.

98.6 Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect
98.7 to participate in the demonstration project and fulfill the requirements under subdivision 3.
98.8 To participate, a provider must notify the commissioner of the provider's intent to participate
98.9 in a format required by the commissioner and enroll as a demonstration project provider.

98.10 Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for
98.11 participating providers that are consistent with the federal requirements of the demonstration
98.12 project.

98.13 (b) Participating residential providers must obtain applicable licensure under chapters
98.14 245F, 245G, or other applicable standards for the services provided and must:

98.15 (1) deliver services in accordance with American Society of Addiction Medicine (ASAM)
98.16 standards;

98.17 (2) maintain formal patient referral arrangements with providers delivering step-up or
98.18 step-down levels of care in accordance with ASAM standards; and

98.19 (3) provide or arrange for medication-assisted treatment services if requested by a client
98.20 for whom an effective medication exists.

98.21 (c) Participating outpatient providers must be licensed and must:

98.22 (1) deliver services in accordance with ASAM standards; and

98.23 (2) maintain formal patient referral arrangements with providers delivering step-up or
98.24 step-down levels of care in accordance with ASAM standards.

98.25 (d) If the provider standards under chapter 245G or other applicable standards conflict
98.26 or are duplicative, the commissioner may grant variances to the standards if the variances
98.27 do not conflict with federal requirements. The commissioner shall publish service
98.28 components, service standards, and staffing requirements for participating providers that
98.29 are consistent with ASAM standards and federal requirements.

98.30 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
98.31 be increased for services provided to medical assistance enrollees.

99.1 (b) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 99.2 (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on
 99.3 January 1, 2020.

99.4 (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph
 99.5 (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the
 99.6 rates in effect on January 1, 2021.

99.7 Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement
 99.8 the demonstration project under this section and to receive federal financial participation.

99.9 Sec. 24. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

99.10 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
 99.11 entitled to a housing support payment to be made on the individual's behalf if the agency
 99.12 has approved the setting where the individual will receive housing support and the individual
 99.13 meets the requirements in paragraph (a), (b), or (c).

99.14 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined
 99.15 under the criteria used by the title II program of the Social Security Act, and meets the
 99.16 resource restrictions and standards of section 256P.02, and the individual's countable income
 99.17 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
 99.18 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
 99.19 income actually made available to a community spouse by an elderly waiver participant
 99.20 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
 99.21 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
 99.22 provider of housing support in which the individual resides.

99.23 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
 99.24 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
 99.25 individual's resources are less than the standards specified by section 256P.02, and the
 99.26 individual's countable income as determined under section 256P.06, less the medical
 99.27 assistance personal needs allowance under section 256B.35 is less than the monthly rate
 99.28 specified in the agency's agreement with the provider of housing support in which the
 99.29 individual resides.

99.30 (c) ~~The individual receives licensed residential crisis stabilization services under section~~
 99.31 ~~256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive~~
 99.32 ~~concurrent housing support payments if receiving licensed residential crisis stabilization~~
 99.33 ~~services under section 256B.0624, subdivision 7. lacks a fixed, adequate, nighttime residence~~

100.1 upon discharge from a residential behavioral health treatment program, as determined by
 100.2 treatment staff from the residential behavioral health treatment program. An individual is
 100.3 eligible under this paragraph for up to three months, including a full or partial month from
 100.4 the individual's move-in date at a setting approved for housing support following discharge
 100.5 from treatment, plus two full months.

100.6 **EFFECTIVE DATE.** This section is effective September 1, 2019.

100.7 Sec. 25. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

100.8 Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision
 100.9 2a, providers shall ensure that participants have at a minimum:

100.10 (1) food preparation and service for three nutritional meals a day on site;

100.11 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

100.12 (3) housekeeping, including cleaning and lavatory supplies or service; and

100.13 (4) maintenance and operation of the building and grounds, including heat, water, garbage
 100.14 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
 100.15 and maintain equipment and facilities.

100.16 (b) Providers serving participants described in subdivision 1, paragraph (c), shall assist
 100.17 participants in applying for continuing housing support payments before the end of the
 100.18 eligibility period.

100.19 **EFFECTIVE DATE.** This section is effective September 1, 2019.

100.20 Sec. 26. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

100.21 Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board
 100.22 payment to be made on behalf of an eligible individual is determined by subtracting the
 100.23 individual's countable income under section 256I.04, subdivision 1, for a whole calendar
 100.24 month from the room and board rate for that same month. The housing support payment is
 100.25 determined by multiplying the housing support rate times the period of time the individual
 100.26 was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

100.27 (b) For an individual with earned income under paragraph (a), prospective budgeting
 100.28 must be used to determine the amount of the individual's payment for the following six-month
 100.29 period. An increase in income shall not affect an individual's eligibility or payment amount
 100.30 until the month following the reporting month. A decrease in income shall be effective the
 100.31 first day of the month after the month in which the decrease is reported.

101.1 (c) For an individual who receives ~~licensed residential crisis stabilization services under~~
 101.2 ~~section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04,
 101.3 subdivision 1, paragraph (c), the amount of housing support payment amount is determined
 101.4 by multiplying the housing support rate times the period of time the individual was a resident.

101.5 **EFFECTIVE DATE.** This section is effective September 1, 2019.

101.6 Sec. 27. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

101.7 Subd. 3a. **Intake procedure; approved mental health screening; data sharing.** As
 101.8 part of its intake procedure for new prisoners, the sheriff or local corrections shall use a
 101.9 mental health screening tool approved by the commissioner of corrections, in consultation
 101.10 with the commissioner of human services and local corrections staff, to identify persons
 101.11 who may have a mental illness. Notwithstanding section 13.85, the sheriff or local corrections
 101.12 may share the names of persons who have screened positive for or may have a mental illness
 101.13 with the local county social services agency. The sheriff or local corrections may refer a
 101.14 person to county personnel of the welfare system, as defined in section 13.46, subdivision
 101.15 1, paragraph (c), in order to arrange for services upon discharge and may share private data
 101.16 on the individual as necessary to:

101.17 (1) provide assistance in filling out an application for medical assistance or
 101.18 MinnesotaCare;

101.19 (2) make a referral for case management as provided under section 245.467, subdivision
 101.20 4;

101.21 (3) provide assistance in obtaining a state photo identification;

101.22 (4) secure a timely appointment with a psychiatrist or other appropriate community
 101.23 mental health provider;

101.24 (5) provide prescriptions for a 30-day supply of all necessary medications; or

101.25 (6) provide for behavioral health service coordination.

101.26 Sec. 28. **REPEALER.**

101.27 (a) Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

101.28 (b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

ARTICLE 4

CONTINUING CARE FOR OLDER ADULTS

102.1
102.2
102.3 Section 1. Minnesota Statutes 2018, section 144A.073, is amended by adding a subdivision
102.4 to read:

102.5 Subd. 16. **Moratorium exception funding.** In fiscal year 2020, the commissioner may
102.6 approve moratorium exception projects under this section for which the full annualized state
102.7 share of medical assistance costs does not exceed \$2,000,000 plus any carryover of previous
102.8 appropriations for this purpose.

102.9 Sec. 2. Minnesota Statutes 2018, section 256R.25, is amended to read:

102.10 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

102.11 (a) The payment rate for external fixed costs is the sum of the amounts in paragraphs

102.12 (b) to ~~(n)~~ (o).

102.13 (b) For a facility licensed as a nursing home, the portion related to the provider surcharge
102.14 under section 256.9657 is equal to \$8.86 per resident day. For a facility licensed as both a
102.15 nursing home and a boarding care home, the portion related to the provider surcharge under
102.16 section 256.9657 is equal to \$8.86 per resident day multiplied by the result of its number
102.17 of nursing home beds divided by its total number of licensed beds.

102.18 (c) The portion related to the licensure fee under section 144.122, paragraph (d), is the
102.19 amount of the fee divided by the sum of the facility's resident days.

102.20 (d) The portion related to development and education of resident and family advisory
102.21 councils under section 144A.33 is \$5 per resident day divided by 365.

102.22 (e) The portion related to scholarships is determined under section 256R.37.

102.23 (f) The portion related to planned closure rate adjustments is as determined under section
102.24 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

102.25 (g) The portion related to consolidation rate adjustments shall be as determined under
102.26 section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

102.27 (h) The portion related to single-bed room incentives is as determined under section
102.28 256R.41.

102.29 (i) The portions related to real estate taxes, special assessments, and payments made in
102.30 lieu of real estate taxes directly identified or allocated to the nursing facility are the actual
102.31 amounts divided by the sum of the facility's resident days. Allowable costs under this

103.1 paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate
 103.2 taxes shall not exceed the amount which the nursing facility would have paid to a city or
 103.3 township and county for fire, police, sanitation services, and road maintenance costs had
 103.4 real estate taxes been levied on that property for those purposes.

103.5 (j) The portion related to employer health insurance costs is the allowable costs divided
 103.6 by the sum of the facility's resident days.

103.7 (k) The portion related to the Public Employees Retirement Association is actual costs
 103.8 divided by the sum of the facility's resident days.

103.9 (l) The portion related to quality improvement incentive payment rate adjustments is
 103.10 the amount determined under section 256R.39.

103.11 (m) The portion related to performance-based incentive payments is the amount
 103.12 determined under section 256R.38.

103.13 (n) The portion related to special dietary needs is the amount determined under section
 103.14 256R.51.

103.15 (o) The portion related to the rate adjustments for border city facilities is the amount
 103.16 determined under section 256R.481.

103.17 Sec. 3. **[256R.481] RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.**

103.18 (a)The commissioner shall allow each nonprofit nursing facility located within the
 103.19 boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once
 103.20 annually for a rate add-on to the facility's external fixed costs payment rate.

103.21 (b) A facility seeking an add-on to its external fixed costs payment rate under this section
 103.22 must apply annually to the commissioner to receive the add-on. A facility must submit the
 103.23 application within 60 calendar days of the effective date of any add-on under this section.
 103.24 The commissioner may waive the deadlines required by this paragraph under extraordinary
 103.25 circumstances.

103.26 (c) The commissioner shall provide the add-on to each eligible facility that applies by
 103.27 the application deadline.

103.28 (d) The add-on to the external fixed costs payment rate is the difference on January 1
 103.29 of the median total payment rate for case mix classification PA1 of the nonprofit facilities
 103.30 located in an adjacent city in another state and in cities contiguous to the adjacent city minus
 103.31 the eligible nursing facility's total payment rate for case mix classification PA1 as determined
 103.32 under section 256R.22, subdivision 4.

104.1 **EFFECTIVE DATE.** The add-on to the external fixed costs payment rate described in
104.2 Minnesota Statutes, section 256R.481, is available for the rate years beginning on and after
104.3 January 1, 2021.

104.4 Sec. 4. **REPEALER.**

104.5 Minnesota Statutes 2018, section 256R.53, subdivision 2, is repealed effective January
104.6 1, 2021.

104.7 **ARTICLE 5**

104.8 **DISABILITY SERVICES**

104.9 Section 1. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

104.10 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
104.11 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
104.12 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
104.13 for a physical location that will not be the primary residence of the license holder for the
104.14 entire period of licensure. If a license is issued during this moratorium, and the license
104.15 holder changes the license holder's primary residence away from the physical location of
104.16 the foster care license, the commissioner shall revoke the license according to section
104.17 245A.07. The commissioner shall not issue an initial license for a community residential
104.18 setting licensed under chapter 245D. When approving an exception under this paragraph,
104.19 the commissioner shall consider the resource need determination process in paragraph (h),
104.20 the availability of foster care licensed beds in the geographic area in which the licensee
104.21 seeks to operate, the results of a person's choices during their annual assessment and service
104.22 plan review, and the recommendation of the local county board. The determination by the
104.23 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

104.29 (3) new foster care licenses or community residential setting licenses determined to be
104.30 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
104.31 or regional treatment center; restructuring of state-operated services that limits the capacity
104.32 of state-operated facilities; or allowing movement to the community for people who no

105.1 longer require the level of care provided in state-operated facilities as provided under section
105.2 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

105.5 (5) new foster care licenses or community residential setting licenses determined to be
105.6 needed by the commissioner for the transition of people from personal care assistance to
105.7 the home and community-based services;

105.8 (6) new foster care licenses or community residential setting licenses determined to be
105.9 needed by the commissioner for the transition of people from the residential care waiver
105.10 services to foster care services. This exception applies only when:

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

105.14 (ii) the person's foster care services are less than or equal to the cost of the person's
105.15 services delivered in the residential care waiver service setting as determined by the lead
105.16 agency; or

105.17 (7) new foster care licenses or community residential setting licenses for people receiving
105.18 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
105.19 for which a license is required. This exception does not apply to people living in their own
105.20 home. For purposes of this clause, there is a presumption that a foster care or community
105.21 residential setting license is required for services provided to three or more people in a
105.22 dwelling unit when the setting is controlled by the provider. A license holder subject to this
105.23 exception may rebut the presumption that a license is required by seeking a reconsideration
105.24 of the commissioner's determination. The commissioner's disposition of a request for
105.25 reconsideration is final and not subject to appeal under chapter 14. The exception is available
105.26 until June 30, ~~2018~~ 2019. This exception is available when:

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

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

106.1 (8) a vacancy in a setting granted an exception under clause (7), created between January
106.2 1, 2017, and the date of the exception request, by the departure of a person receiving services
106.3 under chapter 245D and residing in the unlicensed setting between January 1, 2017, and
106.4 May 1, 2017. This exception is available when the lead agency provides documentation to
106.5 the commissioner on the eligibility criteria being met. This exception is available until June
106.6 30, 2019.

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

106.13 (c) When an adult resident ~~served by the program moves out of a~~ for any reason
106.14 permanently vacates a bed in an adult foster care home that is not the primary residence of
106.15 the license holder according to section 256B.49, subdivision 15, paragraph (f), or the a bed
106.16 in an adult community residential setting, the county shall immediately inform the
106.17 Department of Human Services Licensing Division commissioner. Within six months of
106.18 the second bed being permanently vacated, the department may commissioner shall decrease
106.19 the statewide licensed capacity for adult foster care settings by one bed for every two beds
106.20 vacated.

106.21 (d) Residential settings that would otherwise be subject to the decreased license capacity
106.22 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
106.23 residents whose primary diagnosis is mental illness and the license holder is certified under
106.24 the requirements in subdivision 6a or section 245D.33.

106.25 (e) A resource need determination process, managed at the state level, using the available
106.26 reports required by section 144A.351, and other data and information shall be used to
106.27 determine where the reduced capacity determined under section 256B.493 will be
106.28 implemented. The commissioner shall consult with the stakeholders described in section
106.29 144A.351, and employ a variety of methods to improve the state's capacity to meet the
106.30 informed decisions of those people who want to move out of corporate foster care or
106.31 community residential settings, long-term service needs within budgetary limits, including
106.32 seeking proposals from service providers or lead agencies to change service type, capacity,
106.33 or location to improve services, increase the independence of residents, and better meet
106.34 needs identified by the long-term services and supports reports and statewide data and
106.35 information.

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

107.9 (g) License holders of foster care homes identified under paragraph (f) that are not the
107.10 primary residence of the license holder and that also provide services in the foster care home
107.11 that are covered by a federally approved home and community-based services waiver, as
107.12 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
107.13 licensing division that the license holder provides or intends to provide these waiver-funded
107.14 services.

107.15 (h) The commissioner may adjust capacity to address needs identified in section
107.16 144A.351. Under this authority, the commissioner may approve new licensed settings or
107.17 delicense existing settings. Delicensing of settings will be accomplished through a process
107.18 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
107.19 information and data on capacity of licensed long-term services and supports, actions taken
107.20 under the subdivision to manage statewide long-term services and supports resources, and
107.21 any recommendations for change to the legislative committees with jurisdiction over the
107.22 health and human services budget.

107.23 (i) The commissioner must notify a license holder when its corporate foster care or
107.24 community residential setting licensed beds are reduced under this section. The notice of
107.25 reduction of licensed beds must be in writing and delivered to the license holder by certified
107.26 mail or personal service. The notice must state why the licensed beds are reduced and must
107.27 inform the license holder of its right to request reconsideration by the commissioner. The
107.28 license holder's request for reconsideration must be in writing. If mailed, the request for
107.29 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
107.30 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
107.31 reconsideration is made by personal service, it must be received by the commissioner within
107.32 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

107.33 (j) The commissioner shall not issue an initial license for children's residential treatment
107.34 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
107.35 for a program that Centers for Medicare and Medicaid Services would consider an institution

108.1 for mental diseases. Facilities that serve only private pay clients are exempt from the
108.2 moratorium described in this paragraph. The commissioner has the authority to manage
108.3 existing statewide capacity for children's residential treatment services subject to the
108.4 moratorium under this paragraph and may issue an initial license for such facilities if the
108.5 initial license would not increase the statewide capacity for children's residential treatment
108.6 services subject to the moratorium under this paragraph.

108.7 **EFFECTIVE DATE.** This section is effective July 1, 2019, except the amendment to
108.8 paragraph (a) adding clause (8) is effective retroactively from July 1, 2018, and applies to
108.9 exception requests made on or after that date.

108.10 Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

108.11 Subd. 2a. **Adult foster care and community residential setting license capacity.** (a)
108.12 The commissioner shall issue adult foster care and community residential setting licenses
108.13 with a maximum licensed capacity of four beds, including nonstaff roomers and boarders,
108.14 except that the commissioner may issue a license with a capacity of ~~five~~ up to six beds,
108.15 including roomers and boarders, according to paragraphs (b) to (g).

108.16 (b) The license holder may have a maximum license capacity of five if all persons in
108.17 care are age 55 or over and do not have a serious and persistent mental illness or a
108.18 developmental disability.

108.19 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
108.20 licensed capacity of up to five persons to admit an individual under the age of 55 if the
108.21 variance complies with section 245A.04, subdivision 9, and approval of the variance is
108.22 recommended by the county in which the licensed facility is located.

108.23 (d) The commissioner may grant variances to paragraph (a) to allow the use of an
108.24 additional bed, up to five, for emergency crisis services for a person with serious and
108.25 persistent mental illness or a developmental disability, regardless of age, if the variance
108.26 complies with section 245A.04, subdivision 9, and approval of the variance is recommended
108.27 by the county in which the licensed facility is located.

108.28 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of an
108.29 additional bed, up to five, for respite services, as defined in section 245A.02, for persons
108.30 with disabilities, regardless of age, if the variance complies with sections 245A.03,
108.31 subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended
108.32 by the county in which the licensed facility is located. Respite care may be provided under
108.33 the following conditions:

109.1 (1) staffing ratios cannot be reduced below the approved level for the individuals being
109.2 served in the home on a permanent basis;

109.3 (2) no more than two different individuals can be accepted for respite services in any
109.4 calendar month and the total respite days may not exceed 120 days per program in any
109.5 calendar year;

109.6 (3) the person receiving respite services must have his or her own bedroom, which could
109.7 be used for alternative purposes when not used as a respite bedroom, and cannot be the
109.8 room of another person who lives in the facility; and

109.9 (4) individuals living in the facility must be notified when the variance is approved. The
109.10 provider must give 60 days' notice in writing to the residents and their legal representatives
109.11 prior to accepting the first respite placement. Notice must be given to residents at least two
109.12 days prior to service initiation, or as soon as the license holder is able if they receive notice
109.13 of the need for respite less than two days prior to initiation, each time a respite client will
109.14 be served, unless the requirement for this notice is waived by the resident or legal guardian.

109.15 (f) The commissioner may issue an adult foster care or community residential setting
109.16 license with a capacity of ~~five~~ six adults if the ~~fifth bed does~~ and sixth beds do not increase
109.17 the overall statewide capacity of licensed adult foster care or community residential setting
109.18 beds in homes that are not the primary residence of the license holder, as identified in a plan
109.19 submitted to the commissioner by the county, when the capacity is recommended by the
109.20 county licensing agency of the county in which the facility is located and if the
109.21 recommendation verifies that:

109.22 (1) the facility meets the physical environment requirements in the adult foster care
109.23 licensing rule;

109.24 (2) the five-bed or six-bed living arrangement is specified for each resident in the
109.25 resident's:

109.26 (i) individualized plan of care;

109.27 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

109.28 (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
109.29 subpart 19, if required;

109.30 (3) the license holder obtains written and signed informed consent from each resident
109.31 or resident's legal representative documenting the resident's informed choice to remain
109.32 living in the home and that the resident's refusal to consent would not have resulted in
109.33 service termination; and

110.1 (4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

110.2 (g) The commissioner shall not issue a new adult foster care license under paragraph (f)
110.3 after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care
110.4 license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity
110.5 of five or six adults if the license holder continues to comply with the requirements in
110.6 paragraph (f).

110.7 Sec. 3. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

110.8 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
110.9 and community-based services to persons with disabilities and persons age 65 and older
110.10 pursuant to this chapter. The licensing standards in this chapter govern the provision of
110.11 basic support services and intensive support services.

110.12 (b) Basic support services provide the level of assistance, supervision, and care that is
110.13 necessary to ensure the health and welfare of the person and do not include services that
110.14 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
110.15 person. Basic support services include:

110.16 (1) in-home and out-of-home respite care services as defined in section 245A.02,
110.17 subdivision 15, and under the brain injury, community alternative care, community access
110.18 for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans,
110.19 excluding out-of-home respite care provided to children in a family child foster care home
110.20 licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care
110.21 license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7,
110.22 and 8, or successor provisions; and section 245D.061 or successor provisions, which must
110.23 be stipulated in the statement of intended use required under Minnesota Rules, part
110.24 2960.3000, subpart 4;

110.25 (2) adult companion services as defined under the brain injury, community access for
110.26 disability inclusion, community alternative care, and elderly waiver plans, excluding adult
110.27 companion services provided under the Corporation for National and Community Services
110.28 Senior Companion Program established under the Domestic Volunteer Service Act of 1973,
110.29 Public Law 98-288;

110.30 (3) personal support as defined under the developmental ~~disability~~ disabilities waiver
110.31 plan;

111.1 (4) 24-hour emergency assistance, personal emergency response as defined under the
 111.2 community access for disability inclusion and developmental ~~disability~~ disabilities waiver
 111.3 plans;

111.4 (5) night supervision services as defined under the brain injury, community access for
 111.5 disability inclusion, community alternative care, and developmental disabilities waiver ~~plan~~
 111.6 plans;

111.7 (6) homemaker services as defined under the community access for disability inclusion,
 111.8 brain injury, community alternative care, developmental ~~disability~~ disabilities, and elderly
 111.9 waiver plans, excluding providers licensed by the Department of Health under chapter 144A
 111.10 and those providers providing cleaning services only; and

111.11 (7) individual community living support under section 256B.0915, subdivision 3j.

111.12 (c) Intensive support services provide assistance, supervision, and care that is necessary
 111.13 to ensure the health and welfare of the person and services specifically directed toward the
 111.14 training, habilitation, or rehabilitation of the person. Intensive support services include:

111.15 (1) intervention services, including:

111.16 (i) ~~behavioral~~ positive support services as defined under the brain injury and community
 111.17 access for disability inclusion, community alternative care, and developmental disabilities
 111.18 waiver plans;

111.19 (ii) in-home or out-of-home crisis respite services as defined under the brain injury,
 111.20 community access for disability inclusion, community alternative care, and developmental
 111.21 ~~disability~~ disabilities waiver ~~plan~~ plans; and

111.22 (iii) specialist services as defined under the current brain injury, community access for
 111.23 disability inclusion, community alternative care, and developmental ~~disability~~ disabilities
 111.24 waiver ~~plan~~ plans;

111.25 (2) in-home support services, including:

111.26 (i) in-home family support and supported living services as defined under the
 111.27 developmental ~~disability~~ disabilities waiver plan;

111.28 (ii) independent living services training as defined under the brain injury and community
 111.29 access for disability inclusion waiver plans;

111.30 (iii) semi-independent living services; and

111.31 (iv) individualized home supports services as defined under the brain injury, community
 111.32 alternative care, and community access for disability inclusion waiver plans;

112.1 (3) residential supports and services, including:

112.2 (i) supported living services as defined under the developmental ~~disability~~ disabilities
 112.3 waiver plan provided in a family or corporate child foster care residence, a family adult
 112.4 foster care residence, a community residential setting, or a supervised living facility;

112.5 (ii) foster care services as defined in the brain injury, community alternative care, and
 112.6 community access for disability inclusion waiver plans provided in a family or corporate
 112.7 child foster care residence, a family adult foster care residence, or a community residential
 112.8 setting; and

112.9 (iii) residential services provided to more than four persons with developmental
 112.10 disabilities in a supervised living facility, including ICFs/DD;

112.11 (4) day services, including:

112.12 (i) structured day services as defined under the brain injury waiver plan;

112.13 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
 112.14 under the developmental ~~disability~~ disabilities waiver plan; and

112.15 (iii) prevocational services as defined under the brain injury and community access for
 112.16 disability inclusion waiver plans; and

112.17 (5) employment exploration services as defined under the brain injury, community
 112.18 alternative care, community access for disability inclusion, and developmental ~~disability~~
 112.19 disabilities waiver plans;

112.20 (6) employment development services as defined under the brain injury, community
 112.21 alternative care, community access for disability inclusion, and developmental ~~disability~~
 112.22 disabilities waiver plans; and

112.23 (7) employment support services as defined under the brain injury, community alternative
 112.24 care, community access for disability inclusion, and developmental ~~disability~~ disabilities
 112.25 waiver plans.

112.26 Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

112.27 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
 112.28 person or the person's legal representative and case manager an opportunity to participate
 112.29 in the ongoing review and development of the service plan and the methods used to support
 112.30 the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per
 112.31 year, or within 30 days of a written request by the person, the person's legal representative,
 112.32 or the case manager, the license holder, in coordination with the person's support team or

113.1 expanded support team, must meet with the person, the person's legal representative, and
 113.2 the case manager, and participate in service plan review meetings following stated timelines
 113.3 established in the person's coordinated service and support plan or coordinated service and
 113.4 support plan addendum ~~or within 30 days of a written request by the person, the person's~~
 113.5 ~~legal representative, or the case manager, at a minimum of once per year.~~ The purpose of
 113.6 the service plan review is to determine whether changes are needed to the service plan based
 113.7 on the assessment information, the license holder's evaluation of progress towards
 113.8 accomplishing outcomes, or other information provided by the support team or expanded
 113.9 support team.

113.10 (b) At least once per year, the license holder, in coordination with the person's support
 113.11 team or expanded support team, must meet with the person, the person's legal representative,
 113.12 and the case manager to discuss how technology might be used to meet the person's desired
 113.13 outcomes. The coordinated service and support plan addendum must include a summary of
 113.14 this discussion. The summary must include a statement regarding any decision made related
 113.15 to the use of technology and a description of any further research that must be completed
 113.16 before a decision regarding the use of technology can be made. Nothing in this paragraph
 113.17 requires the coordinated service and support plan addendum to include the use of technology
 113.18 for the provision of services.

113.19 ~~(b)~~ (c) The license holder must summarize the person's status and progress toward
 113.20 achieving the identified outcomes and make recommendations and identify the rationale
 113.21 for changing, continuing, or discontinuing implementation of supports and methods identified
 113.22 in subdivision 4 in a report available at the time of the progress review meeting. The report
 113.23 must be sent at least five working days prior to the progress review meeting if requested by
 113.24 the team in the coordinated service and support plan or coordinated service and support
 113.25 plan addendum.

113.26 ~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum
 113.27 to the person, the person's legal representative, and the case manager by mail within ten
 113.28 working days of the progress review meeting. Within ten working days of the mailing of
 113.29 the coordinated service and support plan addendum, the license holder must obtain dated
 113.30 signatures from the person or the person's legal representative and the case manager to
 113.31 document approval of any changes to the coordinated service and support plan addendum.

113.32 ~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and
 113.33 support plan and coordinated service and support plan addendum, the person or the person's
 113.34 legal representative or case manager has not signed and returned to the license holder the
 113.35 coordinated service and support plan or coordinated service and support plan addendum or

114.1 has not proposed written modifications to the license holder's submission, the submission
114.2 is deemed approved and the coordinated service and support plan addendum becomes
114.3 effective and remains in effect until the legal representative or case manager submits a
114.4 written request to revise the coordinated service and support plan addendum.

114.5 Sec. 5. Minnesota Statutes 2018, section 245D.09, subdivision 5, is amended to read:

114.6 Subd. 5. **Annual training.** A license holder must provide annual training to direct support
114.7 staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff
114.8 has a first aid certification, annual training under subdivision 4, clause (9), is not required
114.9 as long as the certification remains current. ~~A license holder must provide a minimum of~~
114.10 ~~24 hours of annual training to direct service staff providing intensive services and having~~
114.11 ~~fewer than five years of documented experience and 12 hours of annual training to direct~~
114.12 ~~service staff providing intensive services and having five or more years of documented~~
114.13 ~~experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on~~
114.14 ~~relevant topics received from sources other than the license holder may count toward training~~
114.15 ~~requirements. A license holder must provide a minimum of 12 hours of annual training to~~
114.16 ~~direct service staff providing basic services and having fewer than five years of documented~~
114.17 ~~experience and six hours of annual training to direct service staff providing basic services~~
114.18 ~~and having five or more years of documented experience.~~

114.19 Sec. 6. Minnesota Statutes 2018, section 245D.09, subdivision 5a, is amended to read:

114.20 Subd. 5a. **Alternative sources of training.** ~~The commissioner may approve online~~
114.21 ~~training and competency-based assessments in place of a specific number of hours of training~~
114.22 ~~in the topics covered in subdivision 4. The commissioner must provide a list of preapproved~~
114.23 ~~trainings that do not need approval for each individual license holder.~~

114.24 Orientation or training received by the staff person from sources other than the license
114.25 holder in the same subjects as identified in subdivision 4 may count toward the orientation
114.26 and annual training requirements if received in the 12-month period before the staff person's
114.27 date of hire. The license holder must maintain documentation of the training received from
114.28 other sources and of each staff person's competency in the required area according to the
114.29 requirements in subdivision 3.

114.30 Sec. 7. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

114.31 Subd. 2. **Behavior Positive support professional qualifications.** A ~~behavior positive~~
114.32 ~~support professional providing behavioral positive support services as identified in section~~

115.1 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
115.2 following areas as required under the brain injury ~~and~~ ² community access for disability
115.3 inclusion, community alternative care, and developmental disabilities waiver plans or
115.4 successor plans:

115.5 (1) ethical considerations;

115.6 (2) functional assessment;

115.7 (3) functional analysis;

115.8 (4) measurement of behavior and interpretation of data;

115.9 (5) selecting intervention outcomes and strategies;

115.10 (6) behavior reduction and elimination strategies that promote least restrictive approved
115.11 alternatives;

115.12 (7) data collection;

115.13 (8) staff and caregiver training;

115.14 (9) support plan monitoring;

115.15 (10) co-occurring mental disorders or neurocognitive disorder;

115.16 (11) demonstrated expertise with populations being served; and

115.17 (12) must be a:

115.18 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
115.19 of Psychology competencies in the above identified areas;

115.20 (ii) clinical social worker licensed as an independent clinical social worker under chapter
115.21 148D, or a person with a master's degree in social work from an accredited college or
115.22 university, with at least 4,000 hours of post-master's supervised experience in the delivery
115.23 of clinical services in the areas identified in clauses (1) to (11);

115.24 (iii) physician licensed under chapter 147 and certified by the American Board of
115.25 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
115.26 in the areas identified in clauses (1) to (11);

115.27 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
115.28 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
115.29 services who has demonstrated competencies in the areas identified in clauses (1) to (11);

116.1 (v) person with a master's degree from an accredited college or university in one of the
 116.2 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
 116.3 experience in the delivery of clinical services with demonstrated competencies in the areas
 116.4 identified in clauses (1) to (11); ~~or~~

116.5 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
 116.6 fields with demonstrated expertise in positive support services; or

116.7 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
 116.8 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
 116.9 mental health nursing by a national nurse certification organization, or who has a master's
 116.10 degree in nursing or one of the behavioral sciences or related fields from an accredited
 116.11 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
 116.12 experience in the delivery of clinical services.

116.13 Sec. 8. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

116.14 Subd. 3. **Behavior Positive support analyst qualifications.** (a) A ~~behavior positive~~
 116.15 support analyst providing behavioral positive support services as identified in section
 116.16 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
 116.17 following areas as required under the brain injury ~~and~~₂ community access for disability
 116.18 inclusion, community alternative care, and developmental disabilities waiver plans or
 116.19 successor plans:

116.20 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
 116.21 discipline; ~~or~~

116.22 (2) meet the qualifications of a mental health practitioner as defined in section 245.462,
 116.23 subdivision 17; or

116.24 (3) be a board-certified behavior analyst or board-certified assistant behavior analyst by
 116.25 the Behavior Analyst Certification Board, Incorporated.

116.26 (b) In addition, a ~~behavior positive support~~ analyst must:

116.27 (1) have four years of supervised experience ~~working with individuals who exhibit~~
 116.28 ~~challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~
 116.29 conducting functional behavior assessments and designing, implementing, and evaluating
 116.30 effectiveness of positive practices behavior support strategies for people who exhibit
 116.31 challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

117.1 (2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~
 117.2 training prior to hire or within 90 calendar days of hire that includes:

117.3 (i) ten hours of instruction in functional assessment and functional analysis;

117.4 (ii) 20 hours of instruction in the understanding of the function of behavior;

117.5 (iii) ten hours of instruction on design of positive practices behavior support strategies;

117.6 (iv) 20 hours of instruction preparing written intervention strategies, designing data

117.7 collection protocols, training other staff to implement positive practice strategies,

117.8 summarizing and reporting program evaluation data, analyzing program evaluation data to

117.9 identify design flaws in behavioral interventions or failures in implementation fidelity, and

117.10 recommending enhancements based on evaluation data; and

117.11 (v) eight hours of instruction on principles of person-centered thinking;

117.12 ~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

117.13 ~~(4) have received ten hours of instruction on design of positive practices behavior support~~
 117.14 ~~strategies;~~

117.15 ~~(5) have received 20 hours of instruction on the use of behavior reduction approved~~

117.16 ~~strategies used only in combination with behavior positive practices strategies;~~

117.17 ~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training

117.18 and prerequisite skills required to provide positive practice strategies as well as behavior

117.19 reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive

117.20 support; and

117.21 ~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

117.22 (c) Meeting the qualifications for a positive support professional under subdivision 2

117.23 shall substitute for meeting the qualifications listed in paragraph (b).

117.24 Sec. 9. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

117.25 Subd. 4. **Behavior Positive support specialist qualifications.** (a) A ~~behavior~~ positive

117.26 support specialist providing ~~behavioral~~ positive support services as identified in section

117.27 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the

117.28 following areas as required under the brain injury ~~and~~ community access for disability

117.29 inclusion, community alternative care, and developmental disabilities waiver plans or

117.30 successor plans:

117.31 (1) have an associate's degree in a social services discipline; or

118.1 (2) have two years of supervised experience working with individuals who exhibit
 118.2 challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

118.3 (b) In addition, a behavior specialist must:

118.4 (1) have received training prior to hire or within 90 calendar days of hire that includes:

118.5 (i) a minimum of four hours of training in functional assessment;

118.6 ~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of
 118.7 behavior;

118.8 ~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral
 118.9 support strategies; and

118.10 (iv) eight hours of instruction on principles of person-centered thinking;

118.11 ~~(4) (2)~~ be determined by a ~~behavior~~ positive support professional to have the training
 118.12 and prerequisite skills required to provide positive practices strategies as well as behavior
 118.13 reduction approved intervention to the person who receives ~~behavioral~~ positive support;
 118.14 and

118.15 ~~(5) (3)~~ be under the direct supervision of a ~~behavior~~ positive support professional.

118.16 (c) Meeting the qualifications for a positive support professional under subdivision 2
 118.17 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

118.18 Sec. 10. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

118.19 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
 118.20 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
 118.21 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
 118.22 for any person if the costs exceed the state share of the average medical assistance costs for
 118.23 services provided by intermediate care facilities for a person with a developmental disability
 118.24 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
 118.25 person if the costs exceed \$1,500 in a state fiscal year. The commissioner may make
 118.26 payments to each county in quarterly installments. The commissioner may certify an advance
 118.27 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
 118.28 basis for reported expenditures and may be adjusted for anticipated spending patterns.

118.29 Sec. 11. **[256.488] ADAPTIVE FITNESS ACCESS GRANT.**

118.30 Subdivision 1. **Definitions.** (a) "Adaptive fitness" means the practice of physical fitness
 118.31 by an individual with primary physical disabilities, either as a consequence of the natural

119.1 aging process or due to a developmental disability, mental health issue, congenital condition,
119.2 trauma, injury, or disease.

119.3 (b) "Adaptive fitness center" means a center with modified equipment, equipment
119.4 arrangement and space for access, and trainers with skills in modifying exercise programs
119.5 specific to the physical and cognitive needs of individuals with disabilities.

119.6 (c) "Commissioner" means the commissioner of human services.

119.7 (d) "Disability" has the meaning given in the Americans with Disabilities Act.

119.8 Subd. 2. **Establishment.** A statewide adaptive fitness access grant program is established
119.9 under the Department of Human Services to award grants to promote access to adaptive
119.10 fitness for individuals with disabilities.

119.11 Subd. 3. **Application and review.** (a) The commissioner must develop a grant application
119.12 that must contain, at a minimum:

119.13 (1) a description of the purpose or project for which the grant will be used;

119.14 (2) a description of the specific problem the grant intends to address;

119.15 (3) a description of achievable objectives, a work plan, and a timeline for implementation
119.16 and completion of processes or projects enabled by the grant;

119.17 (4) a description of the existing frameworks and experience providing adaptive fitness;
119.18 and

119.19 (5) a proposed process for documenting and evaluating results of the grant.

119.20 (b) An applicant must apply using the grant application developed by the commissioner.

119.21 (c) The commissioner shall review each application. The commissioner shall establish
119.22 criteria to evaluate applications, including but not limited to:

119.23 (1) the application is complete;

119.24 (2) the eligibility of the applicant;

119.25 (3) the thoroughness and clarity in identifying the specific problem the grant intends to
119.26 address;

119.27 (4) a description of the population demographics and service area of the proposed project;

119.28 (5) documentation the grant applicant has received cash or in-kind contributions of value
119.29 equal to the requested grant amount; and

120.1 (6) the proposed project's longevity and demonstrated financial sustainability after the
 120.2 initial grant period.

120.3 (d) In evaluating applications, the commissioner may request additional information
 120.4 regarding a proposed project, including information on project cost. An applicant's failure
 120.5 to timely provide the information requested disqualifies an applicant.

120.6 Subd. 4. **Awards.** (a) The commissioner shall award grants to eligible applicants to
 120.7 provide adaptive fitness for individuals with disabilities.

120.8 (b) The commissioner shall award grants to qualifying nonprofit organizations that
 120.9 provide adaptive fitness in adaptive fitness centers. Grants must be used to assist one or
 120.10 more qualified nonprofit organizations to provide adaptive fitness, including: (1) stay fit;
 120.11 (2) activity-based locomotor exercise; (3) equipment necessary for adaptive fitness programs;
 120.12 (4) operating expenses related to staffing of adaptive fitness programs; and (5) other adaptive
 120.13 fitness programs as deemed appropriate by the commissioner.

120.14 (c) An applicant may apply for and the commissioner may award grants for two-year
 120.15 periods, and the commissioner shall determine the number of grants awarded. The
 120.16 commissioner may reallocate underspending among grantees within the same grant period.

120.17 Subd. 5. **Report.** Beginning December 1, 2020, and every two years thereafter, the
 120.18 commissioner of human services shall submit a report to the chairs and ranking minority
 120.19 members of the legislative committees with jurisdiction over health and human services.
 120.20 The report shall, at a minimum, include the amount of funding awarded for each project, a
 120.21 description of the programs and services funded, plans for the long-term sustainability of
 120.22 the projects, and data on outcomes for the programs and services funded. Grantees must
 120.23 provide information and data requested by the commissioner to support the development
 120.24 of this report.

120.25 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 19a, is amended to
 120.26 read:

120.27 Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care
 120.28 assistance services in a recipient's home. Effective January 1, ~~2010~~ 2020, to qualify for
 120.29 personal care assistance services, a recipient must require assistance and be determined
 120.30 dependent in one critical activity of daily living as defined in section 256B.0659, subdivision
 120.31 1, paragraph ~~(b)~~ (e), or in a Level I behavior as defined in section 256B.0659, subdivision
 120.32 1, paragraph (c), or have a behavior that shows increased vulnerability due to cognitive
 120.33 deficits or socially inappropriate behavior that requires assistance at least four times per

121.1 week. Recipients or responsible parties must be able to identify the recipient's needs, direct
121.2 and evaluate task accomplishment, and provide for health and safety. Approved hours may
121.3 be used outside the home when normal life activities take them outside the home. To use
121.4 personal care assistance services at school, the recipient or responsible party must provide
121.5 written authorization in the care plan identifying the chosen provider and the daily amount
121.6 of services to be used at school. Total hours for services, whether actually performed inside
121.7 or outside the recipient's home, cannot exceed that which is otherwise allowed for personal
121.8 care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654.
121.9 Medical assistance does not cover personal care assistance services for residents of a hospital,
121.10 nursing facility, intermediate care facility, health care facility licensed by the commissioner
121.11 of health, or unless a resident who is otherwise eligible is on leave from the facility and the
121.12 facility either pays for the personal care assistance services or forgoes the facility per diem
121.13 for the leave days that personal care assistance services are used. All personal care assistance
121.14 services must be provided according to sections 256B.0651 to 256B.0654. Personal care
121.15 assistance services may not be reimbursed if the personal care assistant is the spouse or paid
121.16 guardian of the recipient or the parent of a recipient under age 18, or the responsible party
121.17 or the family foster care provider of a recipient who cannot direct the recipient's own care
121.18 unless, in the case of a foster care provider, a county or state case manager visits the recipient
121.19 as needed, but not less than every six months, to monitor the health and safety of the recipient
121.20 and to ensure the goals of the care plan are met. Notwithstanding the provisions of section
121.21 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party
121.22 and not the personal care provider organization, may be reimbursed to provide personal
121.23 care assistance services to the recipient if the guardian or conservator meets all criteria for
121.24 a personal care assistant according to section 256B.0659, and shall not be considered to
121.25 have a service provider interest for purposes of participation on the screening team under
121.26 section 256B.092, subdivision 7.

121.27 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
121.28 whichever is later. The commissioner shall implement the modified eligibility criteria as
121.29 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
121.30 approval is obtained.

121.31 Sec. 13. Minnesota Statutes 2018, section 256B.0652, subdivision 6, is amended to read:

121.32 Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All
121.33 personal care assistance services, supervision by a qualified professional, and additional
121.34 services beyond the limits established in subdivision 11, must be authorized by the
121.35 commissioner or the commissioner's designee before services begin except for the

122.1 assessments established in subdivision 11 and section 256B.0911. The authorization for
122.2 personal care assistance and qualified professional services under section 256B.0659 must
122.3 be completed within 30 days after receiving a complete request.

122.4 (b) The amount of personal care assistance services authorized must be based on the
122.5 recipient's home care rating. The home care rating shall be determined by the commissioner
122.6 or the commissioner's designee based on information submitted to the commissioner
122.7 identifying the following for recipients with dependencies in two or more activities of daily
122.8 living:

122.9 (1) total number of dependencies of activities of daily living as defined in section
122.10 256B.0659;

122.11 (2) presence of complex health-related needs as defined in section 256B.0659; and

122.12 (3) presence of Level I behavior as defined in section 256B.0659.

122.13 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
122.14 total time for personal care assistance services for each home care rating is based on the
122.15 median paid units per day for each home care rating from fiscal year 2007 data for the
122.16 personal care assistance program. Each home care rating has a base level of hours assigned.
122.17 Additional time is added through the assessment and identification of the following:

122.18 (1) 30 additional minutes per day for a dependency in each critical activity of daily living
122.19 as defined in section 256B.0659;

122.20 (2) 30 additional minutes per day for each complex health-related function as defined
122.21 in section 256B.0659; and

122.22 (3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659,
122.23 subdivision 4, paragraph (d).

122.24 (d) Effective July 1, 2011, the home care rating for recipients who have a dependency
122.25 in one activity of daily living or Level I behavior shall equal no more than two units per
122.26 day. Effective January 1, 2020, the home care rating for recipients who have a dependency
122.27 in one critical activity of daily living or one Level I behavior or that require assistance with
122.28 a behavior that shows increased vulnerability due to cognitive deficits or socially
122.29 inappropriate behavior at least four times per week shall equal no more than two units per
122.30 day. Recipients with this home care rating are not subject to the methodology in paragraph
122.31 (c) and are not eligible for more than two units per day.

122.32 (e) A limit of 96 units of qualified professional supervision may be authorized for each
122.33 recipient receiving personal care assistance services. A request to the commissioner to

123.1 exceed this total in a calendar year must be requested by the personal care provider agency
 123.2 on a form approved by the commissioner.

123.3 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 123.4 whichever is later. The commissioner shall implement the modified eligibility criteria as
 123.5 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
 123.6 approval is obtained.

123.7 Sec. 14. Minnesota Statutes 2018, section 256B.0658, is amended to read:

123.8 **256B.0658 HOUSING ACCESS GRANTS.**

123.9 The commissioner of human services shall award through a competitive process contracts
 123.10 for grants to public and private agencies to support and assist individuals ~~eligible for publicly~~
 123.11 ~~funded home and community-based services, including state plan home care~~ with a disability
 123.12 as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may
 123.13 be awarded to agencies that may include, but are not limited to, the following supports:
 123.14 assessment to ensure suitability of housing, accompanying an individual to look at housing,
 123.15 filling out applications and rental agreements, meeting with landlords, helping with Section
 123.16 8 or other program applications, helping to develop a budget, obtaining furniture and
 123.17 household goods, if necessary, and assisting with any problems that may arise with housing.

123.18 Sec. 15. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

123.19 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a
 123.20 recipient's need for personal care assistance services conducted in person. Assessments for
 123.21 personal care assistance services shall be conducted by the county public health nurse or a
 123.22 certified public health nurse under contract with the county except when a long-term care
 123.23 consultation assessment is being conducted for the purposes of determining a person's
 123.24 eligibility for home and community-based waiver services including personal care assistance
 123.25 services according to section 256B.0911. During the transition to MnCHOICES, a certified
 123.26 assessor may complete the assessment defined in this subdivision. An in-person assessment
 123.27 must include: documentation of health status, determination of need, evaluation of service
 123.28 effectiveness, identification of appropriate services, service plan development or modification,
 123.29 coordination of services, referrals and follow-up to appropriate payers and community
 123.30 resources, completion of required reports, recommendation of service authorization, and
 123.31 consumer education. Once the need for personal care assistance services is determined under
 123.32 this section, the county public health nurse or certified public health nurse under contract
 123.33 with the county is responsible for communicating this recommendation to the commissioner

124.1 and the recipient. An in-person assessment must occur at least annually or when there is a
124.2 significant change in the recipient's condition or when there is a change in the need for
124.3 personal care assistance services. A service update may substitute for the annual face-to-face
124.4 assessment when there is not a significant change in recipient condition or a change in the
124.5 need for personal care assistance service. A service update may be completed by telephone,
124.6 used when there is no need for an increase in personal care assistance services, and used
124.7 for two consecutive assessments if followed by a face-to-face assessment. A service update
124.8 must be completed on a form approved by the commissioner. A service update or review
124.9 for temporary increase includes a review of initial baseline data, evaluation of service
124.10 effectiveness, redetermination of service need, modification of service plan and appropriate
124.11 referrals, update of initial forms, obtaining service authorization, and on going consumer
124.12 education. Assessments or reassessments must be completed on forms provided by the
124.13 commissioner within 30 days of a request for home care services by a recipient or responsible
124.14 party.

124.15 (b) This subdivision expires when notification is given by the commissioner as described
124.16 in section 256B.0911, subdivision 3a.

124.17 Sec. 16. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

124.26 (3) enroll with the department as a personal care assistant after clearing a background
124.27 study. Except as provided in subdivision 11a, before a personal care assistant provides
124.28 services, the personal care assistance provider agency must initiate a background study on
124.29 the personal care assistant under chapter 245C, and the personal care assistance provider
124.30 agency must have received a notice from the commissioner that the personal care assistant
124.31 is:

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

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

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

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

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

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

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

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

125.22 (10) be limited to providing and being paid for up to 275 hours per month of personal
125.23 care assistance services regardless of the number of recipients being served or the number
125.24 of personal care assistance provider agencies enrolled with. The number of hours worked
125.25 per day shall not be disallowed by the department unless in violation of the law.

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

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

125.32 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
125.33 17a if the personal care assistant providing the services:

126.1 (1) provides services, according to the care plan in subdivision 7, to a recipient who
126.2 qualifies for ten or more hours per day of personal care assistance services; and

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

126.7 **EFFECTIVE DATE.** This section is effective July 1, 2019.

126.8 Sec. 17. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision
126.9 to read:

126.10 Subd. 17a. **Enhanced rate.** An enhanced rate of 110 percent of the rate paid for personal
126.11 care assistance services shall be paid for services provided to persons who qualify for ten
126.12 or more hours of personal care assistance service per day when provided by a personal care
126.13 assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate
126.14 for personal care assistance services includes, and is not in addition to, any rate adjustments
126.15 implemented by the commissioner to comply with the terms of a collective bargaining
126.16 agreement between the state of Minnesota and an exclusive representative of individual
126.17 providers under section 179A.54 for increased financial incentives for providing services
126.18 to people with complex needs.

126.19 **EFFECTIVE DATE.** This section is effective July 1, 2019.

126.20 Sec. 18. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

126.28 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
126.29 revenue in the previous calendar year is up to and including \$300,000, the provider agency
126.30 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
126.31 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety

- 127.1 bond must be in a form approved by the commissioner, must be renewed annually, and must
127.2 allow for recovery of costs and fees in pursuing a claim on the bond;
- 127.3 (3) proof of fidelity bond coverage in the amount of \$20,000;
- 127.4 (4) proof of workers' compensation insurance coverage;
- 127.5 (5) proof of liability insurance;
- 127.6 (6) a description of the personal care assistance provider agency's organization identifying
127.7 the names of all owners, managing employees, staff, board of directors, and the affiliations
127.8 of the directors, owners, or staff to other service providers;
- 127.9 (7) a copy of the personal care assistance provider agency's written policies and
127.10 procedures including: hiring of employees; training requirements; service delivery; and
127.11 employee and consumer safety including process for notification and resolution of consumer
127.12 grievances, identification and prevention of communicable diseases, and employee
127.13 misconduct;
- 127.14 (8) copies of all other forms the personal care assistance provider agency uses in the
127.15 course of daily business including, but not limited to:
- 127.16 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
127.17 varies from the standard time sheet for personal care assistance services approved by the
127.18 commissioner, and a letter requesting approval of the personal care assistance provider
127.19 agency's nonstandard time sheet;
- 127.20 (ii) the personal care assistance provider agency's template for the personal care assistance
127.21 care plan; and
- 127.22 (iii) the personal care assistance provider agency's template for the written agreement
127.23 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;
- 127.24 (9) a list of all training and classes that the personal care assistance provider agency
127.25 requires of its staff providing personal care assistance services;
- 127.26 (10) documentation that the personal care assistance provider agency and staff have
127.27 successfully completed all the training required by this section, including the requirements
127.28 under subdivision 11, paragraph (d), if enhanced personal care assistance services are
127.29 provided and submitted for an enhanced rate under subdivision 17a;
- 127.30 (11) documentation of the agency's marketing practices;
- 127.31 (12) disclosure of ownership, leasing, or management of all residential properties that
127.32 is used or could be used for providing home care services;

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

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

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

128.18 (c) All personal care assistance provider agencies shall require all employees in
128.19 management and supervisory positions and owners of the agency who are active in the
128.20 day-to-day management and operations of the agency to complete mandatory training as
128.21 determined by the commissioner before enrollment of the agency as a provider. Employees
128.22 in management and supervisory positions and owners who are active in the day-to-day
128.23 operations of an agency who have completed the required training as an employee with a
128.24 personal care assistance provider agency do not need to repeat the required training if they
128.25 are hired by another agency, if they have completed the training within the past three years.
128.26 By September 1, 2010, the required training must be available with meaningful access
128.27 according to title VI of the Civil Rights Act and federal regulations adopted under that law
128.28 or any guidance from the United States Health and Human Services Department. The
128.29 required training must be available online or by electronic remote connection. The required
128.30 training must provide for competency testing. Personal care assistance provider agency
128.31 billing staff shall complete training about personal care assistance program financial
128.32 management. This training is effective July 1, 2009. Any personal care assistance provider
128.33 agency enrolled before that date shall, if it has not already, complete the provider training
128.34 within 18 months of July 1, 2009. Any new owners or employees in management and
128.35 supervisory positions involved in the day-to-day operations are required to complete

129.1 mandatory training as a requisite of working for the agency. Personal care assistance provider
129.2 agencies certified for participation in Medicare as home health agencies are exempt from
129.3 the training required in this subdivision. When available, Medicare-certified home health
129.4 agency owners, supervisors, or managers must successfully complete the competency test.

129.5 **EFFECTIVE DATE.** This section is effective July 1, 2019.

129.6 Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

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

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

129.14 (4) comply with background study requirements;

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

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

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

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

129.22 (9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent
129.23 of the revenue generated by the medical assistance rate for personal care assistance services
129.24 for employee personal care assistant wages and benefits. The revenue generated by the
129.25 qualified professional and the reasonable costs associated with the qualified professional
129.26 shall not be used in making this calculation;

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

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

129.30 (12) report suspected neglect and abuse to the common entry point according to section
129.31 256B.0651;

- 130.1 (13) provide the recipient with a copy of the home care bill of rights at start of service;
- 130.2 ~~and~~
- 130.3 (14) request reassessments at least 60 days prior to the end of the current authorization
- 130.4 for personal care assistance services, on forms provided by the commissioner; and
- 130.5 (15) document that the agency uses the additional revenue due to the enhanced rate under
- 130.6 subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements
- 130.7 under subdivision 11, paragraph (d).

130.8 **EFFECTIVE DATE.** This section is effective July 1, 2019.

130.9 Sec. 20. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

130.10 Subd. 28. **Personal care assistance provider agency; required documentation.** (a)

130.11 Required documentation must be completed and kept in the personal care assistance provider

130.12 agency file or the recipient's home residence. The required documentation consists of:

130.13 (1) employee files, including:

130.14 (i) applications for employment;

130.15 (ii) background study requests and results;

130.16 (iii) orientation records about the agency policies;

130.17 (iv) trainings completed with demonstration of competence, including verification of

130.18 the completion of training required under subdivision 11, paragraph (d), for any services

130.19 billed at the enhanced rate under subdivision 17a;

130.20 (v) supervisory visits;

130.21 (vi) evaluations of employment; and

130.22 (vii) signature on fraud statement;

130.23 (2) recipient files, including:

130.24 (i) demographics;

130.25 (ii) emergency contact information and emergency backup plan;

130.26 (iii) personal care assistance service plan;

130.27 (iv) personal care assistance care plan;

130.28 (v) month-to-month service use plan;

130.29 (vi) all communication records;

- 131.1 (vii) start of service information, including the written agreement with recipient; and
- 131.2 (viii) date the home care bill of rights was given to the recipient;
- 131.3 (3) agency policy manual, including:
- 131.4 (i) policies for employment and termination;
- 131.5 (ii) grievance policies with resolution of consumer grievances;
- 131.6 (iii) staff and consumer safety;
- 131.7 (iv) staff misconduct; and
- 131.8 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
- 131.9 resolution of consumer grievances;
- 131.10 (4) time sheets for each personal care assistant along with completed activity sheets for
- 131.11 each recipient served; and
- 131.12 (5) agency marketing and advertising materials and documentation of marketing activities
- 131.13 and costs.
- 131.14 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do not
- 131.15 consistently comply with the requirements of this subdivision.
- 131.16 **EFFECTIVE DATE.** This section is effective July 1, 2019.
- 131.17 Sec. 21. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:
- 131.18 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:
- 131.19 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
- 131.20 services" means:
- 131.21 (1) intake for and access to assistance in identifying services needed to maintain an
- 131.22 individual in the most inclusive environment;
- 131.23 (2) providing recommendations for and referrals to cost-effective community services
- 131.24 that are available to the individual;
- 131.25 (3) development of an individual's person-centered community support plan;
- 131.26 (4) providing information regarding eligibility for Minnesota health care programs;
- 131.27 (5) face-to-face long-term care consultation assessments, which may be completed in a
- 131.28 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
- 131.29 (ICF/DDs), regional treatment centers, or the person's current or planned residence;

132.1 (6) determination of home and community-based waiver and other service eligibility as
 132.2 required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level
 132.3 of care determination for individuals who need an institutional level of care as determined
 132.4 under subdivision 4e, based on assessment and community support plan development,
 132.5 appropriate referrals to obtain necessary diagnostic information, and including an eligibility
 132.6 determination for consumer-directed community supports;

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

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

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

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

132.21 (1) service eligibility determination for state plan ~~home care~~ services identified in:

132.22 (i) section 256B.0625, subdivisions 7, 19a, and 19c;

132.23 (ii) consumer support grants under section 256.476; or

132.24 (iii) section 256B.85;

132.25 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
 132.26 ~~determination of eligibility for gaining access to~~ case management services available under
 132.27 sections 256B.0621, subdivision 2, ~~paragraph clause~~ (4), and 256B.0924, and Minnesota
 132.28 Rules, part 9525.0016;

132.29 (3) ~~determination of institutional level of care, home and community-based service~~
 132.30 ~~waiver, and other service of eligibility as required under section 256B.092, determination~~
 132.31 ~~of eligibility for family support grants under section 252.32, for semi-independent living~~
 132.32 ~~services under section 252.275, and day training and habilitation services under section~~
 132.33 ~~256B.092; and~~

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

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

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

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

133.12 (f) "Person-centered planning" is a process that includes the active participation of a
133.13 person in the planning of the person's services, including in making meaningful and informed
133.14 choices about the person's own goals, talents, and objectives, as well as making meaningful
133.15 and informed choices about the services the person receives. For the purposes of this section,
133.16 "informed choice" means a voluntary choice of services by a person from all available
133.17 service options based on accurate and complete information concerning all available service
133.18 options and concerning the person's own preferences, abilities, goals, and objectives. In
133.19 order for a person to make an informed choice, all available options must be developed and
133.20 presented to the person to empower the person to make decisions.

133.21 Sec. 22. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

134.6 (d) The assessment must be conducted in a face-to-face conversational interview with
134.7 the person being assessed ~~and~~. The person's legal representative must provide input during
134.8 the assessment process and may do so remotely if requested. At the request of the person,
134.9 other individuals may participate in the assessment to provide information on the needs,
134.10 strengths, and preferences of the person necessary to develop a community support plan
134.11 that ensures the person's health and safety. Except for legal representatives or family members
134.12 invited by the person, persons participating in the assessment may not be a provider of
134.13 service or have any financial interest in the provision of services. For persons who are to
134.14 be assessed for elderly waiver customized living or adult day services under section
134.15 256B.0915, with the permission of the person being assessed or the person's designated or
134.16 legal representative, the client's current or proposed provider of services may submit a copy
134.17 of the provider's nursing assessment or written report outlining its recommendations regarding
134.18 the client's care needs. The person conducting the assessment must notify the provider of
134.19 the date by which this information is to be submitted. This information shall be provided
134.20 to the person conducting the assessment prior to the assessment. For a person who is to be
134.21 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
134.22 the person being assessed or the person's designated legal representative, the person's current
134.23 provider of services may submit a written report outlining recommendations regarding the
134.24 person's care needs ~~prepared by a direct service employee with at least 20 hours of service~~
134.25 ~~to that client. The person conducting the assessment or reassessment must notify the provider~~
134.26 ~~of the date by which this information is to be submitted. This information shall be provided~~
134.27 ~~to the person conducting the assessment and the person or the person's legal representative,~~
134.28 ~~and must be considered prior to the finalization of the assessment or reassessment~~ the person
134.29 completed in consultation with someone who is known to the person and has interaction
134.30 with the person on a regular basis. The provider must submit the report at least 60 days
134.31 before the end of the person's current service agreement. The certified assessor must consider
134.32 the content of the submitted report prior to finalizing the person's assessment or reassessment.

134.33 (e) The certified assessor and the individual responsible for developing the coordinated
134.34 service and support plan must complete the community support plan and the coordinated
134.35 service and support plan no more than 60 calendar days from the assessment visit. The

135.1 person or the person's legal representative must be provided with a written community
135.2 support plan within ~~40 calendar days of the assessment visit~~ the timelines established by
135.3 the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota
135.4 health care programs.

135.5 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
135.6 provider who submitted information under paragraph (d) shall receive the final written
135.7 community support plan when available and the Residential Services Workbook.

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

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

135.10 (2) the individual's options and choices to meet identified needs, including all available
135.11 options for case management services and providers, including service provided in a
135.12 non-disability-specific setting;

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

135.15 (4) referral information; and

135.16 (5) informal caregiver supports, if applicable.

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

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

135.25 (i) The person has the right to make the final decision between institutional placement
135.26 and community placement after the recommendations have been provided, except as provided
135.27 in section 256.975, subdivision 7a, paragraph (d).

135.28 (j) The lead agency must give the person receiving assessment or support planning, or
135.29 the person's legal representative, materials, and forms supplied by the commissioner
135.30 containing the following information:

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

136.1 (2) documentation that the most cost-effective alternatives available were offered to the
136.2 individual. For purposes of this clause, "cost-effective" means community services and
136.3 living arrangements that cost the same as or less than institutional care. For an individual
136.4 found to meet eligibility criteria for home and community-based service programs under
136.5 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
136.6 approved waiver plan for each program;

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

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

136.17 (5) information about Minnesota health care programs;

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

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

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

136.25 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
136.26 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
136.27 (8), and (b), and incorporating the decision regarding the need for institutional level of care
136.28 or the lead agency's final decisions regarding public programs eligibility according to section
136.29 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
136.30 to the person and must visually point out where in the document the right to appeal is stated.

136.31 (k) Face-to-face assessment completed as part of eligibility determination for the
136.32 alternative care, elderly waiver, developmental disabilities, community access for disability
136.33 inclusion, community alternative care, and brain injury waiver programs under sections

137.1 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for
137.2 no more than 60 calendar days after the date of assessment.

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

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

137.14 (n) At the time of reassessment, the certified assessor shall assess each person receiving
137.15 waiver services currently residing in a community residential setting, or licensed adult foster
137.16 care home that is not the primary residence of the license holder, or in which the license
137.17 holder is not the primary caregiver, to determine if that person would prefer to be served in
137.18 a community-living setting as defined in section 256B.49, subdivision 23. The certified
137.19 assessor shall offer the person, through a person-centered planning process, the option to
137.20 receive alternative housing and service options.

137.21 Sec. 23. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

137.22 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
137.23 Prior to a face-to-face reassessment, the certified assessor must review the person's most
137.24 recent assessment. Reassessments must be tailored using the professional judgment of the
137.25 assessor to the person's known needs, strengths, preferences, and circumstances.
137.26 Reassessments provide information to support the person's informed choice and opportunities
137.27 to express choice regarding activities that contribute to quality of life, as well as information
137.28 and opportunity to identify goals related to desired employment, community activities, and
137.29 preferred living environment. Reassessments ~~allow for~~ require a review of the most recent
137.30 assessment, review of the current coordinated service and support plan's effectiveness,
137.31 monitoring of services, and the development of an updated person-centered community
137.32 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
137.33 and provide an opportunity for quality assurance of service delivery. ~~Face-to-face assessments~~
137.34 reassessments must be conducted annually or as required by federal and state laws and rules.

138.1 For reassessments, the certified assessor and the individual responsible for developing the
 138.2 coordinated service and support plan must ensure the continuity of care for the person
 138.3 receiving services and complete the updated community support plan and the updated
 138.4 coordinated service and support plan no more than 60 days from the reassessment visit.

138.5 (b) The commissioner shall develop mechanisms for providers and case managers to
 138.6 share information with the assessor to facilitate a reassessment and support planning process
 138.7 tailored to the person's current needs and preferences.

138.8 Sec. 24. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision
 138.9 to read:

138.10 Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by
 138.11 federal law, the county agency is not required to conduct or arrange for an annual needs
 138.12 reassessment by a certified assessor. The case manager who works on behalf of the person
 138.13 to identify the person's needs and to minimize the impact of the disability on the person's
 138.14 life must instead develop a person-centered service plan based on the person's assessed
 138.15 needs and preferences. The person-centered service plan must be reviewed annually for
 138.16 persons with developmental disabilities who are receiving only case management services
 138.17 under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an
 138.18 assessment under this section.

138.19 Sec. 25. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

138.20 **Subd. 5. Administrative activity.** (a) The commissioner shall streamline the processes,
 138.21 including timelines for when assessments need to be completed, required to provide the
 138.22 services in this section and shall implement integrated solutions to automate the business
 138.23 processes to the extent necessary for community support plan approval, reimbursement,
 138.24 program planning, evaluation, and policy development.

138.25 (b) The commissioner of human services shall work with lead agencies responsible for
 138.26 conducting long-term consultation services to modify the MnCHOICES application and
 138.27 assessment policies to create efficiencies while ensuring federal compliance with medical
 138.28 assistance and long-term services and supports eligibility criteria.

138.29 (c) The commissioner shall work with lead agencies responsible for conducting long-term
 138.30 consultation services to develop a set of measurable benchmarks sufficient to demonstrate
 138.31 quarterly improvement in the average time per assessment and other mutually agreed upon
 138.32 measures of increasing efficiency. The commissioner shall collect data on these benchmarks
 138.33 and provide to the lead agencies and the chairs and ranking minority members of the

139.1 legislative committees with jurisdiction over human services an annual trend analysis of
 139.2 the data in order to demonstrate the commissioner's compliance with the requirements of
 139.3 this subdivision.

139.4 Sec. 26. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

139.5 Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly
 139.6 waiver client shall be provided a copy of a written coordinated service and support plan
 139.7 ~~which~~ that:

139.8 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
 139.9 ~~manager receives the assessment information and written community support plan as~~
 139.10 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
 139.11 established by the commissioner. The timeline for completing the community support plan
 139.12 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
 139.13 not exceed 60 calendar days from the assessment visit;

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

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

139.18 (4) identifies the person's preferences for services as stated by the person or the person's
 139.19 legal guardian or conservator;

139.20 (5) reflects the person's informed choice between institutional and community-based
 139.21 services, as well as choice of services, supports, and providers, including available case
 139.22 manager providers;

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

139.24 (7) identifies specific services and the amount, frequency, duration, and cost of the
 139.25 services to be provided to the person based on assessed needs, preferences, and available
 139.26 resources;

139.27 (8) includes information about the right to appeal decisions under section 256.045; and

139.28 (9) includes the authorized annual and estimated monthly amounts for the services.

139.29 (b) In developing the coordinated service and support plan, the case manager should
 139.30 also include the use of volunteers, religious organizations, social clubs, and civic and service
 139.31 organizations to support the individual in the community. The lead agency must be held

140.1 harmless for damages or injuries sustained through the use of volunteers and agencies under
140.2 this paragraph, including workers' compensation liability.

140.3 Sec. 27. Minnesota Statutes 2018, section 256B.0915, subdivision 10, is amended to read:

140.4 Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner
140.5 shall adjust the elderly waiver capitation payment rates for managed care organizations paid
140.6 under section 256B.69, subdivisions 6b and 23, to reflect the maximum service rate limits
140.7 for customized living services and 24-hour customized living services under subdivisions
140.8 3e and 3h, and the rate adjustment under subdivision 18. Medical assistance rates paid to
140.9 customized living providers by managed care organizations under this section shall not
140.10 exceed the maximum service rate limits and component rates as determined by the
140.11 commissioner under subdivisions 3e and 3h, plus any rate adjustment under subdivision
140.12 18.

140.13 Sec. 28. Minnesota Statutes 2018, section 256B.0915, is amended by adding a subdivision
140.14 to read:

140.15 Subd. 18. **Disproportionate share establishment customized living rate**
140.16 **adjustment.** (a) For purposes of this section, "designated disproportionate share
140.17 establishment" means a housing with services establishment registered under chapter 144D
140.18 that meets the requirements of paragraph (d).

140.19 (b) A housing with services establishment registered under chapter 144D may apply
140.20 annually between June 1 and June 15 to the commissioner to be designated as a
140.21 disproportionate share establishment. The applying housing with services establishment
140.22 must apply to the commissioner in the manner determined by the commissioner. The applying
140.23 housing with services establishment must document as a percentage the census of elderly
140.24 waiver participants residing in the establishment on May 31 of the year of application.

140.25 (c) Only a housing with services establishment registered under chapter 144D with a
140.26 census of at least 50 percent elderly waiver participants on May 31 of the application year
140.27 is eligible under this section for designation as a disproportionate share establishment.

140.28 (d) By June 30, the commissioner shall designate as a disproportionate share establishment
140.29 any housing with services establishment that complies with the requirements of paragraph
140.30 (b) and meets the eligibility criteria described in paragraph (c).

140.31 (e) A designated disproportionate share establishment's customized living rate adjustment
140.32 is the sum of 0.83 plus the product of 0.36 multiplied by the percentage of elderly waiver

141.1 participants residing in the establishment as reported on the establishment's most recent
 141.2 application for designation as a disproportionate share establishment. No establishment may
 141.3 receive a customized living rate adjustment greater than 1.10.

141.4 (f) The commissioner shall multiply the customized living rate and 24-hour customized
 141.5 living rate for a designated disproportionate share establishment by the amount determined
 141.6 under paragraph (e).

141.7 (g) The value of the rate adjustment under paragraph (e) shall not be included in an
 141.8 individual elderly waiver client's monthly case mix budget cap.

141.9 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 141.10 whichever is later, and applies to rates paid on or after January 1, 2021. The commissioner
 141.11 of human services shall inform the revisor of statutes when federal approval is obtained.

141.12 Sec. 29. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

141.13 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
 141.14 community-based waived services shall be provided a copy of the written coordinated
 141.15 service and support plan ~~which~~ that:

141.16 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
 141.17 ~~manager receives the assessment information and written community support plan as~~
 141.18 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
 141.19 established by the commissioner. The timeline for completing the community support plan
 141.20 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
 141.21 not exceed 60 calendar days from the assessment visit;

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

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

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

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

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

142.2 (7) identifies specific services and the amount and frequency of the services to be provided
142.3 to the person based on assessed needs, preferences, and available resources. The coordinated
142.4 service and support plan shall also specify other services the person needs that are not
142.5 available;

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

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

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

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

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

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

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

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

142.25 Sec. 30. Minnesota Statutes 2018, section 256B.092, is amended by adding a subdivision
142.26 to read:

142.27 Subd. 12a. **Developmental disabilities waiver growth limit.** The commissioner shall
142.28 limit the total number of people receiving developmental disabilities waiver services to the
142.29 number of people receiving developmental disabilities waiver services on June 30, 2019.
142.30 The commissioner shall only add new recipients when an existing recipient permanently
142.31 leaves the program. The commissioner shall reserve capacity, within enrollment limits, to
142.32 re-enroll persons who temporarily discontinue and then resume waiver services within 90

143.1 days of the date that services were discontinued. When adding a new recipient, the
 143.2 commissioner shall target persons who meet the priorities for accessing waiver services
 143.3 identified in subdivision 12. The allocation limits include conversions from intermediate
 143.4 care facilities for persons with developmental disabilities unless capacity at the facility is
 143.5 permanently converted to home and community-based services through the developmental
 143.6 disabilities waiver.

143.7 Sec. 31. Minnesota Statutes 2018, section 256B.0921, is amended to read:

143.8 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE**
 143.9 **INNOVATION POOL.**

143.10 The commissioner of human services shall develop an initiative to provide incentives
 143.11 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
 143.12 competitive employment for youth under age 25 upon their graduation from school; (3)
 143.13 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
 143.14 The commissioner shall seek requests for proposals and shall contract with one or more
 143.15 entities to provide incentive payments for meeting identified outcomes.

143.16 Sec. 32. Minnesota Statutes 2018, section 256B.49, is amended by adding a subdivision
 143.17 to read:

143.18 **Subd. 11b. Community access for disability inclusion waiver growth limit. The**
 143.19 **commissioner shall limit the total number of people receiving community access for disability**
 143.20 **inclusion waiver services to the number of people receiving community access for disability**
 143.21 **inclusion waiver services on June 30, 2019. The commissioner shall only add new recipients**
 143.22 **when an existing recipient permanently leaves the program. The commissioner shall reserve**
 143.23 **capacity, within enrollment limits, to re-enroll persons who temporarily discontinue and**
 143.24 **then resume waiver services within 90 days of the date that services were discontinued.**
 143.25 **When adding a new recipient, the commissioner shall target individuals who meet the**
 143.26 **priorities for accessing waiver services identified in subdivision 11a. The allocation limits**
 143.27 **includes conversions and diversions from nursing facilities.**

143.28 Sec. 33. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

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

144.1 (1) finalizing the written coordinated service and support plan within ~~ten working days~~
144.2 ~~after the case manager receives the plan from the certified assessor~~ the timelines established
144.3 by the commissioner. The timeline for completing the community support plan under section
144.4 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed
144.5 60 calendar days from the assessment visit;

144.6 (2) informing the recipient or the recipient's legal guardian or conservator of service
144.7 options;

144.8 (3) assisting the recipient in the identification of potential service providers and available
144.9 options for case management service and providers, including services provided in a
144.10 non-disability-specific setting;

144.11 (4) assisting the recipient to access services and assisting with appeals under section
144.12 256.045; and

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

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

144.18 (1) finalizing the coordinated service and support plan;

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

144.21 (3) adjustments to the coordinated service and support plan.

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

144.29 (d) For persons who need a positive support transition plan as required in chapter 245D,
144.30 the case manager shall participate in the development and ongoing evaluation of the plan
144.31 with the expanded support team. At least quarterly, the case manager, in consultation with
144.32 the expanded support team, shall evaluate the effectiveness of the plan based on progress
144.33 evaluation data submitted by the licensed provider to the case manager. The evaluation must

145.1 identify whether the plan has been developed and implemented in a manner to achieve the
145.2 following within the required timelines:

145.3 (1) phasing out the use of prohibited procedures;

145.4 (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's
145.5 timeline; and

145.6 (3) accomplishment of identified outcomes.

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

145.10 Sec. 34. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

145.11 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
145.12 conducted by certified assessors according to section 256B.0911, subdivision 2b. The
145.13 certified assessor, with the permission of the recipient or the recipient's designated legal
145.14 representative, may invite other individuals to attend the assessment. With the permission
145.15 of the recipient or the recipient's designated legal representative, the recipient's current
145.16 provider of services may submit a written report outlining their recommendations regarding
145.17 the recipient's care needs prepared by a direct service employee ~~with at least 20 hours of~~
145.18 ~~service to that client. The certified assessor must notify the provider of the date by which~~
145.19 ~~this information is to be submitted. This information shall be provided to the certified~~
145.20 ~~assessor and the person or the person's legal representative and must be considered prior to~~
145.21 ~~the finalization of the assessment or reassessment~~ who is familiar with the person. The
145.22 provider must submit the report at least 60 days before the end of the person's current service
145.23 agreement. The certified assessor must consider the content of the submitted report prior
145.24 to finalizing the person's assessment or reassessment.

145.25 (b) There must be a determination that the client requires a hospital level of care or a
145.26 nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and
145.27 subsequent assessments to initiate and maintain participation in the waiver program.

145.28 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
145.29 appropriate to determine nursing facility level of care for purposes of medical assistance
145.30 payment for nursing facility services, only face-to-face assessments conducted according
145.31 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
145.32 determination or a nursing facility level of care determination must be accepted for purposes
145.33 of initial and ongoing access to waiver services payment.

146.1 (d) Recipients who are found eligible for home and community-based services under
146.2 this section before their 65th birthday may remain eligible for these services after their 65th
146.3 birthday if they continue to meet all other eligibility factors.

146.4 Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

146.13 (e) "Direct care staff" means employees providing direct services to an individual
146.14 receiving services under this section. Direct care staff excludes executive, managerial, or
146.15 administrative staff.

146.16 ~~(e)~~ (f) "Disability waiver rates system" means a statewide system that establishes rates
146.17 that are based on uniform processes and captures the individualized nature of waiver services
146.18 and recipient needs.

146.19 ~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to
146.20 an individual recipient by staff to provide direct support and assistance with activities of
146.21 daily living, instrumental activities of daily living, and training to participants, and is based
146.22 on the requirements in each individual's coordinated service and support plan under section
146.23 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
146.24 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
146.25 needs must also be considered.

146.26 ~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged
146.27 with administering waived services under sections 256B.092 and 256B.49.

146.28 ~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups,
146.29 one-half above the median and one-half below the median.

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

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

147.4 ~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded
147.5 under any of the disability waivers.

147.6 ~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
147.7 (f), providing or available to provide more than one individual with direct support and
147.8 assistance with activities of daily living as defined under section 256B.0659, subdivision
147.9 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
147.10 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
147.11 training to participants, and is based on the requirements in each individual's coordinated
147.12 service and support plan under section 245D.02, subdivision 4b; any coordinated service
147.13 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
147.14 provider observation of an individual's service need. Total shared staffing hours are divided
147.15 proportionally by the number of individuals who receive the shared service provisions.

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

147.20 ~~(n)~~ (o) "Unit of service" means the following:

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

147.24 (2) for day services under subdivision 7:

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

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

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

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

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

148.3 (iii) for prevocational services, a unit of service is a day or ~~an hour~~ 15 minutes. A day
 148.4 unit of service is six or more hours of time spent providing direct service;

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

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

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

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

148.12 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

148.17 (1) 24-hour customized living;

148.18 (2) adult day care;

148.19 (3) adult day care bath;

148.20 ~~(4) behavioral programming;~~

148.21 ~~(5)~~ (4) companion services;

148.22 ~~(6)~~ (5) customized living;

148.23 ~~(7)~~ (6) day training and habilitation;

148.24 (7) employment development services;

148.25 (8) employment exploration services;

148.26 (9) employment support services;

148.27 ~~(8)~~ (10) housing access coordination;

148.28 ~~(9)~~ (11) independent living skills;

148.29 (12) independent living skills specialist services;

- 149.1 (13) individualized home supports;
- 149.2 ~~(10)~~ (14) in-home family support;
- 149.3 ~~(11)~~ (15) night supervision;
- 149.4 ~~(12)~~ (16) personal support;
- 149.5 (17) positive support service;
- 149.6 ~~(13)~~ (18) prevocational services;
- 149.7 ~~(14)~~ (19) residential care services;
- 149.8 ~~(15)~~ (20) residential support services;
- 149.9 ~~(16)~~ (21) respite services;
- 149.10 ~~(17)~~ (22) structured day services;
- 149.11 ~~(18)~~ (23) supported employment services;
- 149.12 ~~(19)~~ (24) supported living services;
- 149.13 ~~(20)~~ (25) transportation services; and
- 149.14 ~~(21) individualized home supports;~~
- 149.15 ~~(22) independent living skills specialist services;~~
- 149.16 ~~(23) employment exploration services;~~
- 149.17 ~~(24) employment development services;~~
- 149.18 ~~(25) employment support services; and~~
- 149.19 (26) other services as approved by the federal government in the state home and
- 149.20 community-based services plan.

149.21 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

149.22 Subd. 5. **Base wage index and standard component values.** (a) The base wage index

149.23 is established to determine staffing costs associated with providing services to individuals

149.24 receiving home and community-based services. For purposes of developing and calculating

149.25 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard

149.26 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in

149.27 the most recent edition of the Occupational Handbook must be used. The base wage index

149.28 must be calculated as follows:

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

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

150.5 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
150.6 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
150.7 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
150.8 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
150.9 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

150.10 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
150.11 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
150.12 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

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

150.16 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
150.17 counselors (SOC code 21-1014);

150.18 (5) for behavior program professional staff, 100 percent of the median wage for clinical
150.19 counseling and school psychologist (SOC code 19-3031);

150.20 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
150.21 technicians (SOC code 29-2053);

150.22 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
150.23 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
150.24 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
150.25 21-1093);

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

150.28 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
150.29 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
150.30 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
150.31 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
150.32 code 29-2053);

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

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

151.9 (12) for independent living skills specialist staff, 100 percent of mental health and
151.10 substance abuse social worker (SOC code 21-1023);

151.11 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
151.12 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
151.13 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
151.14 21-1093);

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

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

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

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

151.27 (18) for night supervision staff, 20 percent of the median wage for home health aide
151.28 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
151.29 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
151.30 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
151.31 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

152.1 (19) for respite staff, 50 percent of the median wage for personal and home care aide
152.2 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
152.3 31-1014);

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

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

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

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

152.15 (b) The commissioner shall adjust the base wage index in paragraph (j) with a competitive
152.16 workforce factor of 4.7 percent to provide increased compensation to direct care staff. A
152.17 provider shall use the additional revenue from the competitive workforce factor to increase
152.18 wages for or to improve benefits provided to direct care staff.

152.19 (c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall
152.20 report to the chairs and ranking minority members of the legislative committees and divisions
152.21 with jurisdiction over health and human services policy and finance an analysis of the
152.22 competitive workforce factor. The report shall include recommendations to adjust the
152.23 competitive workforce factor using (1) the most recently available wage data by SOC code
152.24 of the weighted average wage for direct care staff for residential services and direct care
152.25 staff for day services; (2) the most recently available wage data by SOC code of the weighted
152.26 average wage of comparable occupations; and (3) labor market data as required under
152.27 subdivision 10a, paragraph (g). The commissioner shall not recommend in any biennial
152.28 report an increase or decrease of the competitive workforce factor by more than two
152.29 percentage points from the current value. If, after a biennial analysis for the next report, the
152.30 competitive workforce factor is less than or equal to zero, the commissioner shall recommend
152.31 a competitive workforce factor of zero.

152.32 ~~(b)~~ (d) Component values for residential support services are:

152.33 (1) supervisory span of control ratio: 11 percent;

- 153.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 153.2 (3) employee-related cost ratio: 23.6 percent;
- 153.3 (4) general administrative support ratio: 13.25 percent;
- 153.4 (5) program-related expense ratio: 1.3 percent; and
- 153.5 (6) absence and utilization factor ratio: 3.9 percent.
- 153.6 ~~(e)~~ (e) Component values for family foster care are:
- 153.7 (1) supervisory span of control ratio: 11 percent;
- 153.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 153.9 (3) employee-related cost ratio: 23.6 percent;
- 153.10 (4) general administrative support ratio: 3.3 percent;
- 153.11 (5) program-related expense ratio: 1.3 percent; and
- 153.12 (6) absence factor: 1.7 percent.
- 153.13 ~~(d)~~ (f) Component values for day services for all services are:
- 153.14 (1) supervisory span of control ratio: 11 percent;
- 153.15 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 153.16 (3) employee-related cost ratio: 23.6 percent;
- 153.17 (4) program plan support ratio: 5.6 percent;
- 153.18 (5) client programming and support ratio: ten percent;
- 153.19 (6) general administrative support ratio: 13.25 percent;
- 153.20 (7) program-related expense ratio: 1.8 percent; and
- 153.21 (8) absence and utilization factor ratio: 9.4 percent.
- 153.22 ~~(e)~~ (g) Component values for unit-based services with programming are:
- 153.23 (1) supervisory span of control ratio: 11 percent;
- 153.24 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 153.25 (3) employee-related cost ratio: 23.6 percent;
- 153.26 (4) program plan supports ratio: 15.5 percent;
- 153.27 (5) client programming and supports ratio: 4.7 percent;

154.1 (6) general administrative support ratio: 13.25 percent;

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

154.3 (8) absence and utilization factor ratio: 3.9 percent.

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

154.6 (1) supervisory span of control ratio: 11 percent;

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

154.8 (3) employee-related cost ratio: 23.6 percent;

154.9 (4) program plan support ratio: 7.0 percent;

154.10 (5) client programming and support ratio: 2.3 percent;

154.11 (6) general administrative support ratio: 13.25 percent;

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

154.13 (8) absence and utilization factor ratio: 3.9 percent.

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

154.15 (1) supervisory span of control ratio: 11 percent;

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

154.17 (3) employee-related cost ratio: 23.6 percent;

154.18 (4) general administrative support ratio: 13.25 percent;

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

154.20 (6) absence and utilization factor ratio: 3.9 percent.

154.21 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~

154.22 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~

154.23 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~

154.24 ~~values and load them into the rate management system.~~ (j) On July 1, 2022, and every five

154.25 two years thereafter, the commissioner shall update the base wage index in paragraph (a)

154.26 ~~based on the most recently available~~ wage data by SOC from the Bureau of Labor Statistics

154.27 available 30 months and one day prior to the scheduled update. The commissioner shall

154.28 publish these updated values and load them into the rate management system.

155.1 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
155.2 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
155.3 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
155.4 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~
155.5 ~~percentage change in the Consumer Price Index-All Items, United States city average~~
155.6 ~~(CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these~~
155.7 ~~updated values and load them into the rate management system. (k) On July 1, 2022, and~~
155.8 ~~every five two years thereafter, the commissioner shall update the framework components~~
155.9 ~~in paragraph (d) (f), clause (5); paragraph (e) (g), clause (5); and paragraph (f) (h), clause~~
155.10 ~~(5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for~~
155.11 ~~changes in the Consumer Price Index. The commissioner shall adjust these values higher~~
155.12 ~~or lower by the percentage change in the CPI-U from the date of the previous update to the~~
155.13 ~~date of the data most recently available 30 months and one day prior to the scheduled update.~~
155.14 ~~The commissioner shall publish these updated values and load them into the rate management~~
155.15 ~~system.~~

155.16 (l) Upon the implementation of automatic inflation adjustments under paragraphs (j)
155.17 and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013,
155.18 chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall
155.19 be removed from service rates calculated under this section.

155.20 (m) Any rate adjustments applied to the service rates calculated under this section outside
155.21 of the cost components and rate methodology specified in this section shall be removed
155.22 from rate calculations upon implementation of automatic inflation adjustments under
155.23 paragraphs (j) and (k).

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

155.27 (o) The commissioner shall update the general administrative support ratio in paragraph
155.28 (b), clause (4); paragraph (c), clause (4); paragraph (d), clause (6); paragraph (e), clause
155.29 (6); paragraph (f), clause (6); and paragraph (g), clause (4), for any changes to the annual
155.30 licensing fee under section 245A.10, subdivision 4, paragraph (b). The commissioner shall
155.31 adjust these ratios higher or lower by an amount equal in value to the percent change in
155.32 general administrative support costs attributable to the change in the licensing fee. The
155.33 commissioner shall publish these updated ratios and load them into the rate management
155.34 system.

156.1 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 156.2 whichever is later, except the new paragraphs (b) and (o) are effective January 1, 2020, or
 156.3 upon federal approval, whichever is later. The commissioner of human services shall notify
 156.4 the revisor of statutes when federal approval is obtained.

156.5 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

156.6 Subd. 10. **Updating payment values and additional information.** ~~(a) From January~~
 156.7 ~~1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform~~
 156.8 ~~procedures to refine terms and adjust values used to calculate payment rates in this section.~~

156.9 ~~(b)~~ (a) No later than July 1, 2014, the commissioner shall, within available resources,
 156.10 begin to conduct research and gather data and information from existing state systems or
 156.11 other outside sources on the following items:

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

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

156.16 (3) the distinct underlying costs for services provided by a license holder under sections
 156.17 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
 156.18 by a license holder certified under section 245D.33.

156.19 ~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
 156.20 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
 156.21 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~
 156.22 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
 156.23 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
 156.24 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
 156.25 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
 156.26 ~~shall be issued by December 31, 2018.~~

156.27 ~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
 156.28 shall begin the review and evaluation of the following values already in subdivisions ~~6~~ 5 to
 156.29 9, or issues that impact all services, including, but not limited to:

156.30 (1) values for transportation rates;

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

156.32 (3) values for indirect services;

- 157.1 (4) values for nursing;
- 157.2 (5) values for the facility use rate in day services, and the weightings used in the day
157.3 service ratios and adjustments to those weightings;
- 157.4 (6) values for workers' compensation as part of employee-related expenses;
- 157.5 (7) values for unemployment insurance as part of employee-related expenses;
- 157.6 (8) direct care workforce labor market measures;
- 157.7 (9) any changes in state or federal law with a direct impact on the underlying cost of
157.8 providing home and community-based services; ~~and~~
- 157.9 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and
157.10 community-based services rates determined under this section; and
- 157.11 (11) different competitive workforce factors by service.
- 157.12 ~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members
157.13 of the legislative committees and divisions with jurisdiction over health and human services
157.14 policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a)
157.15 and (b) on the following dates:
- 157.16 ~~(1) January 15, 2015, with preliminary results and data;~~
- 157.17 ~~(2) January 15, 2016, with a status implementation update, and additional data and~~
157.18 ~~summary information;~~
- 157.19 ~~(3) January 15, 2017, with the full report; and~~
- 157.20 ~~(4) January 15, 2020~~ 2021, with another full report, and a full report once every four
157.21 years thereafter.
- 157.22 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~
157.23 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~
157.24 January 1, 2022, the commissioner shall renew analysis and implement changes to the
157.25 regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h),~~
157.26 ~~occur~~ once every six years. Prior to implementation, the commissioner shall consult with
157.27 stakeholders on the methodology to calculate the adjustment.
- 157.28 ~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of
157.29 each year beginning October 1, 2014, containing information detailing legislatively approved
157.30 changes in:

- 158.1 (1) calculation values including derived wage rates and related employee and
 158.2 administrative factors;
- 158.3 (2) service utilization;
- 158.4 (3) county and tribal allocation changes; and
- 158.5 (4) information on adjustments made to calculation values and the timing of those
 158.6 adjustments.

158.7 The information in this notice must be effective January 1 of the following year.

158.8 ~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient
 158.9 to meet the needs of an individual who enrolled in residential services after January 1, 2014,
 158.10 or insufficient to meet the needs of an individual with a service agreement adjustment
 158.11 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
 158.12 shall be used.

158.13 ~~(i) The commissioner shall study the underlying cost of absence and utilization for day
 158.14 services. Based on the commissioner's evaluation of the data collected under this paragraph,
 158.15 the commissioner shall make recommendations to the legislature by January 15, 2018, for
 158.16 changes, if any, to the absence and utilization factor ratio component value for day services.~~

158.17 ~~(j)~~ (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip
 158.18 information for all day services through the rates management system.

158.19 (h) The commissioner, in consultation with stakeholders, shall study value-based models
 158.20 and outcome-based payment strategies for fee-for-service home and community-based
 158.21 services and report to the legislative committees with jurisdiction over the disability waiver
 158.22 rate system by October 1, 2020, with recommended strategies to improve the quality,
 158.23 efficiency, and effectiveness of services.

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

158.25 Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to
 158.26 read:

158.27 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
 158.28 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 158.29 service. As determined by the commissioner, in consultation with stakeholders identified
 158.30 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
 158.31 determined under this section must submit requested cost data to the commissioner to support

159.1 research on the cost of providing services that have rates determined by the disability waiver
159.2 rates system. Requested cost data may include, but is not limited to:

159.3 (1) worker wage costs;

159.4 (2) benefits paid;

159.5 (3) supervisor wage costs;

159.6 (4) executive wage costs;

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

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

159.9 (7) administrative costs paid;

159.10 (8) program costs paid;

159.11 (9) transportation costs paid;

159.12 (10) vacancy rates; and

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

159.15 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
159.16 year that ended not more than 18 months prior to the submission date. The commissioner
159.17 shall provide each provider a 90-day notice prior to its submission due date. If a provider
159.18 fails to submit required reporting data, the commissioner shall provide notice to providers
159.19 that have not provided required data 30 days after the required submission date, and a second
159.20 notice for providers who have not provided required data 60 days after the required
159.21 submission date. The commissioner shall temporarily suspend payments to the provider if
159.22 cost data is not received 90 days after the required submission date. Withheld payments
159.23 shall be made once data is received by the commissioner.

159.24 (c) The commissioner shall conduct a random validation of data submitted under
159.25 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
159.26 in paragraph (a) and provide recommendations for adjustments to cost components.

159.27 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
159.28 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
159.29 recommendations on component values and inflationary factor adjustments to the chairs
159.30 and ranking minority members of the legislative committees with jurisdiction over human
159.31 services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make

160.1 recommendations in conjunction with reports submitted to the legislature according to
160.2 subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate
160.3 form, and cost data from individual providers shall not be released except as provided for
160.4 in current law.

160.5 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
160.6 subdivision 5, shall develop and implement a process for providing training and technical
160.7 assistance necessary to support provider submission of cost documentation required under
160.8 paragraph (a).

160.9 (f) By December 31, 2020, providers paid with rates calculated under subdivision 5,
160.10 paragraph (b), shall identify additional revenues from the competitive workforce factor and
160.11 prepare a written distribution plan for the revenues. A provider shall make the provider's
160.12 distribution plan available and accessible to all direct care staff for a minimum of one
160.13 calendar year. Upon request, a provider shall submit the written distribution plan to the
160.14 commissioner.

160.15 (g) Providers enrolled to provide services with rates determined under section 256B.4914,
160.16 subdivision 3, shall submit labor market data to the commissioner annually on or before
160.17 November 1, including but not limited to:

160.18 (1) number of direct care staff;

160.19 (2) wages of direct care staff;

160.20 (3) overtime wages of direct care staff;

160.21 (4) hours worked by direct care staff;

160.22 (5) overtime hours worked by direct care staff;

160.23 (6) benefits provided to direct care staff;

160.24 (7) direct care staff job vacancies; and

160.25 (8) direct care staff retention rates.

160.26 (h) The commissioner shall publish annual reports on provider and state-level labor
160.27 market data, including but not limited to the data obtained under paragraph (g).

160.28 (i) The commissioner shall temporarily suspend payments to the provider if data requested
160.29 under paragraph (g) is not received 90 days after the required submission date. Withheld
160.30 payments shall be made once data is received by the commissioner.

161.1 **EFFECTIVE DATE.** This section is effective the day following final enactment except
161.2 paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1,
161.3 2020.

161.4 Sec. 40. Minnesota Statutes 2018, section 256B.493, subdivision 1, is amended to read:

161.5 Subdivision 1. **Commissioner's duties; report.** The commissioner of human services
161.6 has the authority to manage statewide licensed corporate foster care or community residential
161.7 settings capacity, including the reduction and realignment of licensed capacity of a current
161.8 foster care or community residential setting to accomplish the consolidation or closure of
161.9 settings. The commissioner shall implement a program for planned closure of licensed
161.10 corporate adult foster care or community residential settings, necessary as a preferred method
161.11 to: (1) respond to the informed decisions of those individuals who want to move out of these
161.12 settings into other types of community settings; and (2) achieve ~~necessary budgetary savings~~
161.13 the reduction of statewide licensed capacity required in section 245A.03, subdivision 7,
161.14 paragraphs (c) and (d). Closure determinations by the commissioner are final and not subject
161.15 to appeal.

161.16 Sec. 41. Minnesota Statutes 2018, section 256B.5013, subdivision 1, is amended to read:

161.17 Subdivision 1. **Variable rate adjustments.** ~~(a) For rate years beginning on or after~~
161.18 ~~October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD
161.19 recipient, the county of financial responsibility may recommend a variable rate to enable
161.20 the facility to meet the individual's increased needs. Variable rate adjustments made under
161.21 this subdivision replace payments for persons with special needs for crisis intervention
161.22 services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a~~
161.23 ~~base rate above the 50th percentile of the statewide average reimbursement rate for a Class~~
161.24 ~~A facility or Class B facility, whichever matches the facility licensure, are not eligible for~~
161.25 ~~a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,~~
161.26 ~~except when approved for purposes established in paragraph (b), clause (1).~~ Once approved,
161.27 variable rate adjustments must continue to remain in place unless there is an identified
161.28 change in need. A review of needed resources must be done at the time of the individual's
161.29 annual support plan meeting. A request to adjust the resources of the individual must be
161.30 submitted if any change in need is identified. Variable rate adjustments approved solely on
161.31 the basis of changes on a developmental disabilities screening document will end June 30,
161.32 2002.

162.1 (b) The county of financial responsibility must act on a variable rate request within 30
 162.2 days and notify the initiator of the request of the county's recommendation in writing.

162.3 ~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility
 162.4 for increased needs in the following situations:

162.5 (1) a need for resources due to an individual's full or partial retirement from participation
 162.6 in a day training and habilitation service when the individual: (i) has reached the age of 65
 162.7 or has a change in health condition that makes it difficult for the person to participate in
 162.8 day training and habilitation services over an extended period of time because it is medically
 162.9 contraindicated; and (ii) has expressed a desire for change through the developmental
 162.10 disability screening process under section 256B.092;

162.11 (2) a need for additional resources for intensive short-term programming which is
 162.12 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

162.13 (3) a demonstrated medical need that significantly impacts the type or amount of services
 162.14 needed by the individual; ~~or~~

162.15 (4) a demonstrated behavioral or cognitive need that significantly impacts the type or
 162.16 amount of services needed by the individual; ~~;~~ or

162.17 ~~(e) The county of financial responsibility must justify the purpose, the projected length~~
 162.18 ~~of time, and the additional funding needed for the facility to meet the needs of the individual.~~

162.19 ~~(d) The facility shall provide an annual report to the county case manager on the use of~~
 162.20 ~~the variable rate funds and the status of the individual on whose behalf the funds were~~
 162.21 ~~approved. The county case manager will forward the facility's report with a recommendation~~
 162.22 ~~to the commissioner to approve or disapprove a continuation of the variable rate.~~

162.23 ~~(e) Funds made available through the variable rate process that are not used by the facility~~
 162.24 ~~to meet the needs of the individual for whom they were approved shall be returned to the~~
 162.25 ~~state.~~

162.26 (5) a demonstrated increased need for staff assistance, changes in the type of staff
 162.27 credentials needed, or a need for expert consultation based on assessments conducted prior
 162.28 to the annual support plan meeting.

162.29 (d) Variable rate requests must include the following information:

162.30 (1) the service needs change;

162.31 (2) the variable rate requested and the difference from the current rate;

163.1 (3) a basis for the underlying costs used for the variable rate and any accompanying
 163.2 documentation; and

163.3 (4) documentation of the expected outcomes to be achieved and the frequency of progress
 163.4 monitoring associated with the rate increase.

163.5 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
 163.6 whichever is later. The commissioner of human services shall inform the revisor of statutes
 163.7 when federal approval is obtained.

163.8 Sec. 42. Minnesota Statutes 2018, section 256B.5013, subdivision 6, is amended to read:

163.9 Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

163.10 (1) make a determination to approve, deny, or modify a request for a variable rate
 163.11 adjustment within 30 days of the receipt of the completed application;

163.12 (2) notify the ICF/DD facility and county case manager of the ~~duration and conditions~~
 163.13 ~~of variable rate adjustment approvals~~ determination; and

163.14 (3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved
 163.15 variable rates.

163.16 Sec. 43. Minnesota Statutes 2018, section 256B.5015, subdivision 2, is amended to read:

163.17 Subd. 2. **Services during the day.** (a) Services during the day, as defined in section
 163.18 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through
 163.19 payment ~~no later than January 1, 2004~~. The commissioner shall establish rates for these
 163.20 services, other than day training and habilitation services, at ~~levels that do not exceed 75~~
 163.21 100 percent of a recipient's day training and habilitation service costs prior to the service
 163.22 change.

163.23 (b) An individual qualifies for services during the day under paragraph (a) if:

163.24 (1) through consultation with the individual and their support team or interdisciplinary
 163.25 team, it has been determined that the individual's needs can best be met through partial or
 163.26 full retirement from:

163.27 (i) participation in a day training and habilitation service; or

163.28 (ii) the use of services during the day in the individual's home environment; and

163.29 (2) in consultation with the individual and their support team or interdisciplinary team,
 163.30 an individualized plan has been developed with designated outcomes that:

164.1 (i) addresses the support needs and desires contained in the person-centered plan or
 164.2 individual support plan; and

164.3 (ii) includes goals that focus on community integration as appropriate for the individual.

164.4 (c) When establishing a rate for these services, the commissioner shall also consider an
 164.5 individual recipient's needs as identified in the ~~individualized service~~ individual support
 164.6 plan and the person's need for active treatment as defined under federal regulations. The
 164.7 pass-through payments for services during the day shall be paid separately by the
 164.8 commissioner and shall not be included in the computation of the ICF/DD facility total
 164.9 payment rate.

164.10 Sec. 44. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

164.11 Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

164.12 (1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056,
 164.13 or 256B.057, subdivisions 5 and 9;

164.14 (2) is a participant in the alternative care program under section 256B.0913;

164.15 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
 164.16 256B.49; or

164.17 (4) has medical services identified in a person's individualized education program and
 164.18 is eligible for services as determined in section 256B.0625, subdivision 26.

164.19 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
 164.20 meet all of the following:

164.21 (1) based on an assessment under section 256B.0911, require assistance and be determined
 164.22 dependent in one critical activity of daily living or one Level I behavior ~~based on assessment~~
 164.23 ~~under section 256B.0911~~ or have a behavior that shows increased vulnerability due to
 164.24 cognitive deficits or socially inappropriate behavior that requires assistance at least four
 164.25 times per week; and

164.26 (2) is not a participant under a family support grant under section 252.32.

164.27 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
 164.28 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
 164.29 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
 164.30 determined under section 256B.0911.

165.1 Sec. 45. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

165.2 Subd. 8. **Determination of CFSS service authorization amount.** (a) All community
 165.3 first services and supports must be authorized by the commissioner or the commissioner's
 165.4 designee before services begin. The authorization for CFSS must be completed as soon as
 165.5 possible following an assessment but no later than 40 calendar days from the date of the
 165.6 assessment.

165.7 (b) The amount of CFSS authorized must be based on the participant's home care rating
 165.8 described in paragraphs (d) and (e) and any additional service units for which the participant
 165.9 qualifies as described in paragraph (f).

165.10 (c) The home care rating shall be determined by the commissioner or the commissioner's
 165.11 designee based on information submitted to the commissioner identifying the following for
 165.12 a participant:

165.13 (1) the total number of dependencies of activities of daily living;

165.14 (2) the presence of complex health-related needs; and

165.15 (3) the presence of Level I behavior.

165.16 (d) The methodology to determine the total service units for CFSS for each home care
 165.17 rating is based on the median paid units per day for each home care rating from fiscal year
 165.18 2007 data for the PCA program.

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

165.21 (1) ~~P~~ LT home care rating requires ~~Level I behavior or one to three dependencies in~~
 165.22 ~~ADLs and qualifies the person for five service units~~ the presence of increased vulnerability
 165.23 due to cognitive deficits and socially inappropriate behavior that requires assistance at least
 165.24 four times per week, the presence of a Level I behavior, or a dependency in one critical
 165.25 activity of daily living, and qualifies the person for two service units;

165.26 (2) P home care rating requires two to three dependencies in ADLs, one of which must
 165.27 be a critical ADL, and qualifies the person for five services units;

165.28 (3) Q home care rating requires Level I behavior and ~~one~~ two to three dependencies in
 165.29 ADLs, one of which must be a critical ADL, and qualifies the person for six service units;

165.30 ~~(3)~~ (4) R home care rating requires a complex health-related need and ~~one~~ two to three
 165.31 dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for
 165.32 seven service units;

166.1 ~~(4)~~(5) S home care rating requires four to six dependencies in ADLs, one of which must
166.2 be a critical ADL, and qualifies the person for ten service units;

166.3 ~~(5)~~(6) T home care rating requires Level I behavior and four to six dependencies in
166.4 ADLs ~~and Level I behavior~~, one of which must be a critical ADL, and qualifies the person
166.5 for 11 service units;

166.6 ~~(6)~~(7) U home care rating requires four to six dependencies in ADLs, one of which
166.7 must be a critical ADL, and a complex health-related need and qualifies the person for 14
166.8 service units;

166.9 ~~(7)~~(8) V home care rating requires seven to eight dependencies in ADLs and qualifies
166.10 the person for 17 service units;

166.11 ~~(8)~~(9) W home care rating requires seven to eight dependencies in ADLs and Level I
166.12 behavior and qualifies the person for 20 service units;

166.13 ~~(9)~~(10) Z home care rating requires seven to eight dependencies in ADLs and a complex
166.14 health-related need and qualifies the person for 30 service units; and

166.15 ~~(10)~~(11) EN home care rating includes ventilator dependency as defined in section
166.16 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of
166.17 ventilator-dependent and the EN home care rating and utilize a combination of CFSS and
166.18 home care nursing services is limited to a total of 96 service units per day for those services
166.19 in combination. Additional units may be authorized when a person's assessment indicates
166.20 a need for two staff to perform activities. Additional time is limited to 16 service units per
166.21 day.

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

166.24 (1) 30 additional minutes per day for a dependency in each critical activity of daily
166.25 living;

166.26 (2) 30 additional minutes per day for each complex health-related need; and

166.27 (3) 30 additional minutes per day when the behavior requires assistance at least four
166.28 times per week for one or more of the following behaviors:

166.29 (i) level I behavior;

166.30 (ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
166.31 or

167.1 (iii) increased need for assistance for participants who are verbally aggressive or resistive
167.2 to care so that the time needed to perform activities of daily living is increased.

167.3 (g) The service budget for budget model participants shall be based on:

167.4 (1) assessed units as determined by the home care rating; and

167.5 (2) an adjustment needed for administrative expenses.

167.6 Sec. 46. Minnesota Statutes 2018, section 256C.23, is amended by adding a subdivision
167.7 to read:

167.8 Subd. 7. **Family and community intervener.** "Family and community intervener"
167.9 means a paraprofessional, specifically trained in deafblindness, who works one-on-one with
167.10 a child who is deafblind to provide critical connections to people and the environment.

167.11 Sec. 47. Minnesota Statutes 2018, section 256C.261, is amended to read:

167.12 **256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND.**

167.13 (a) The commissioner of human services shall use at least 35 percent of the deafblind
167.14 services biennial base level grant funding for services and other supports for a child who is
167.15 deafblind and the child's family. The commissioner shall use at least 25 percent of the
167.16 deafblind services biennial base level grant funding for services and other supports for an
167.17 adult who is deafblind.

167.18 The commissioner shall award grants for the purposes of:

167.19 (1) providing services and supports to persons who are deafblind; and

167.20 (2) developing and providing training to counties and the network of senior citizen
167.21 service providers. The purpose of the training grants is to teach counties how to use existing
167.22 programs that capture federal financial participation to meet the needs of eligible persons
167.23 who are deafblind and to build capacity of senior service programs to meet the needs of
167.24 seniors with a dual sensory hearing and vision loss.

167.25 (b) The commissioner may make grants:

167.26 (1) for services and training provided by organizations; and

167.27 (2) to develop and administer consumer-directed services.

167.28 (c) Consumer-directed services shall be provided in whole by grant-funded providers.
167.29 The Deaf and Hard-of-Hearing Services Division's regional service centers shall not provide
167.30 any aspect of a grant-funded consumer-directed services program.

168.1 (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under
168.2 paragraph (a).

168.3 (e) Deafblind service providers may, but are not required to, provide intervenor services
168.4 as part of the service package provided with grant funds under this section. Intervener
168.5 services include services provided by a family and community intervenor as described in
168.6 paragraph (f).

168.7 (f) The family and community intervenor, as defined in section 256C.23, subdivision 7,
168.8 provides services to open channels of communication between the child and others; facilitate
168.9 the development or use of receptive and expressive communication skills by the child; and
168.10 develop and maintain a trusting, interactive relationship that promotes social and emotional
168.11 well-being. The family and community intervenor also provides access to information and
168.12 the environment, and facilitates opportunities for learning and development. A family and
168.13 community intervenor must have specific training in deafblindness, building language and
168.14 communication skills, and intervention strategies.

168.15 Sec. 48. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

168.16 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
168.17 services provided to individuals in addition to room and board including, but not limited
168.18 to, oversight and up to 24-hour supervision, medication reminders, assistance with
168.19 transportation, arranging for meetings and appointments, and arranging for medical and
168.20 social services, and services identified in section 256I.03, subdivision 12.

168.21 Sec. 49. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

168.22 Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers
168.23 of housing support must be in writing on a form developed and approved by the commissioner
168.24 and must specify the name and address under which the establishment subject to the
168.25 agreement does business and under which the establishment, or service provider, if different
168.26 from the group residential housing establishment, is licensed by the Department of Health
168.27 or the Department of Human Services; the specific license or registration from the
168.28 Department of Health or the Department of Human Services held by the provider and the
168.29 number of beds subject to that license; the address of the location or locations at which
168.30 group residential housing is provided under this agreement; the per diem and monthly rates
168.31 that are to be paid from housing support funds for each eligible resident at each location;
168.32 the number of beds at each location which are subject to the agreement; whether the license
168.33 holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code;

169.1 and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06
 169.2 and subject to any changes to those sections.

169.3 (b) Providers are required to verify the following minimum requirements in the
 169.4 agreement:

169.5 (1) current license or registration, including authorization if managing or monitoring
 169.6 medications;

169.7 (2) all staff who have direct contact with recipients meet the staff qualifications;

169.8 (3) the provision of housing support;

169.9 (4) the provision of supplementary services, if applicable;

169.10 (5) reports of adverse events, including recipient death or serious injury; ~~and~~

169.11 (6) submission of residency requirements that could result in recipient eviction; and

169.12 (7) confirmation that the provider will not limit or restrict the number of hours an
 169.13 applicant or recipient chooses to be employed, as specified in subdivision 5.

169.14 (c) Agreements may be terminated with or without cause by the commissioner, the
 169.15 agency, or the provider with two calendar months prior notice. The commissioner may
 169.16 immediately terminate an agreement under subdivision 2d.

169.17 Sec. 50. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
 169.18 to read:

169.19 Subd. 2h. **Required supplementary services.** Providers of supplementary services shall
 169.20 ensure that recipients have, at a minimum, assistance with services as identified in the
 169.21 recipient's professional statement of need under section 256I.03, subdivision 12. Providers
 169.22 of supplementary services shall maintain case notes with the date and description of services
 169.23 provided to individual recipients.

169.24 Sec. 51. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
 169.25 to read:

169.26 Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number
 169.27 of hours an applicant or recipient is employed.

169.28 Sec. 52. Minnesota Statutes 2018, section 256I.05, subdivision 1r, is amended to read:

169.29 Subd. 1r. **Supplemental rate; Anoka County.** (a) Notwithstanding the provisions in
 169.30 this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to

170.1 the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
170.2 1a, including any legislatively authorized inflationary adjustments, for a housing support
170.3 provider that is located in Anoka County and provides emergency housing on the former
170.4 Anoka Regional Treatment Center campus.

170.5 (b) Notwithstanding the provisions in this section, a county agency shall negotiate a
170.6 supplemental rate for six beds in addition to the rate specified in subdivision 1, not to exceed
170.7 the maximum rate allowed under subdivision 1a, including any legislatively authorized
170.8 inflationary adjustments, for a housing support provider located in Anoka County that
170.9 operates a 12-bed facility and provides room and board and supplementary services to
170.10 individuals 18 to 24 years of age.

170.11 **EFFECTIVE DATE.** This section is effective July 1, 2019.

170.12 Sec. 53. **[268A.061] HOME AND COMMUNITY-BASED PROVIDERS.**

170.13 Subdivision 1. **Home and community-based provider eligibility for**
170.14 **payments.** Notwithstanding Minnesota Rules, part 3300.5060, subparts 14 to 16, the
170.15 commissioner shall make payments for job-related services, vocational adjustment training,
170.16 and vocational evaluation services to any home and community-based services provider
170.17 licensed as an intensive support services provider under chapter 245D with whom the
170.18 commissioner has signed a limited-use vendor operating agreement.

170.19 Subd. 2. **Limited-use agreements with home and community-based providers.** A
170.20 limited-use vendor operating agreement under this section may not limit the dollar amount
170.21 the provider may receive annually. The limited-use vendor operating agreement available
170.22 under this section must specify at a minimum that payments under the agreement are limited
170.23 to vocational rehabilitation services provided to individuals to whom the provider has
170.24 previously provided day services as described under section 245D.03, subdivision 1,
170.25 paragraph (c), clause (4), or any of the employment services described under section 245D.03,
170.26 subdivision 1, paragraph (c), clauses (5) to (7).

170.27 Subd. 3. **Required limited-use agreements.** The commissioner must enter into a
170.28 limited-use vendor operating agreement that meets at least the minimal requirements of
170.29 subdivision 2 with a provider eligible under subdivision 1 if:

170.30 (1) the home and community-based provider is not a current vocational rehabilitation
170.31 services provider;

171.1 (2) each individual to be served under the limited-use vendor operating agreement was
171.2 receiving day or employment services from the provider immediately prior to the provider
171.3 serving the individual under the terms of the agreement; and

171.4 (3) each individual to be served under the limited-use vendor operating agreement has
171.5 made an informed choice to remain with the provider.

171.6 Sec. 54. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to
171.7 read:

171.8 Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
171.9 **BUDGET METHODOLOGY EXCEPTION.**

171.10 (a) No later than September 30, 2017, if necessary, the commissioner of human services
171.11 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
171.12 and community-based services waivers authorized under Minnesota Statutes, sections
171.13 256B.092 and 256B.49, to expand the exception to the consumer-directed community
171.14 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide
171.15 up to 30 percent more funds for either:

171.16 (1) consumer-directed community supports participants who have a coordinated service
171.17 and support plan which identifies the need for an increased amount of services or supports
171.18 under consumer-directed community supports than the amount they are currently receiving
171.19 under the consumer-directed community supports budget methodology:

171.20 (i) to increase the amount of time a person works or otherwise improves employment
171.21 opportunities;

171.22 (ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes,
171.23 section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or paragraph (g), clause~~
171.24 (1), item (iii); or

171.25 (iii) to develop and implement a positive behavior support plan; or

171.26 (2) home and community-based waiver participants who are currently using licensed
171.27 providers for (i) employment supports or services during the day; or (ii) residential services,
171.28 either of which cost more annually than the person would spend under a consumer-directed
171.29 community supports plan for any or all of the supports needed to meet the goals identified
171.30 in paragraph (a), clause (1), items (i), (ii), and (iii).

171.31 (b) The exception under paragraph (a), clause (1), is limited to those persons who can
171.32 demonstrate that they will have to discontinue using consumer-directed community supports

172.1 and accept other non-self-directed waiver services because their supports needed for the
 172.2 goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within
 172.3 the consumer-directed community supports budget limits.

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

172.8 Sec. 55. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to
 172.9 read:

172.10 Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
 172.11 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
 172.12 **CRISIS RESIDENTIAL SETTINGS.**

172.13 Subdivision 1. Exception for persons leaving institutions and crisis residential
 172.14 settings. (a) By September 30, 2017, the commissioner shall establish an institutional and
 172.15 crisis bed consumer-directed community supports budget exception process in the home
 172.16 and community-based services waivers under Minnesota Statutes, sections 256B.092 and
 172.17 256B.49. This budget exception process shall be available for any individual who:

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

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

172.22 (b) Institutional settings for purposes of this exception include intermediate care facilities
 172.23 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
 172.24 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
 172.25 exception shall be limited to no more than the amount of appropriate services provided in
 172.26 a noninstitutional setting as determined by the lead agency managing the individual's home
 172.27 and community-based services waiver. The lead agency shall notify the Department of
 172.28 Human Services of the budget exception.

172.29 Subd. 2. Shared services. (a) Medical assistance payments for shared services under
 172.30 consumer-directed community supports are limited to this subdivision.

173.1 (b) For purposes of this subdivision, "shared services" means services provided at the
173.2 same time by the same direct care worker for individuals who have entered into an agreement
173.3 to share consumer-directed community support services.

173.4 (c) Shared services may include services in the personal assistance category as outlined
173.5 in the consumer-directed community supports community support plan and shared services
173.6 agreement, except:

173.7 (1) services for more than three individuals provided by one worker at one time;

173.8 (2) use of more than one worker for the shared services; and

173.9 (3) a child care program licensed under chapter 245A or operated by a local school
173.10 district or private school.

173.11 (d) The individuals or, as needed, their representatives shall develop the plan for shared
173.12 services when developing or amending the consumer-directed community supports plan,
173.13 and must follow the consumer-directed community supports process for approval of the
173.14 plan by the lead agency. The plan for shared services in an individual's consumer-directed
173.15 community supports plan shall include the intention to utilize shared services based on
173.16 individuals' needs and preferences.

173.17 (e) Individuals sharing services must use the same financial management services
173.18 provider.

173.19 (f) Individuals whose consumer-directed community supports community support plans
173.20 include the intention to utilize shared services must also jointly develop, with the support
173.21 of their representatives as needed, a shared services agreement. This agreement must include:

173.22 (1) the names of the individuals receiving shared services;

173.23 (2) the individuals' representative, if identified in their consumer-directed community
173.24 supports plans, and their duties;

173.25 (3) the names of the case managers;

173.26 (4) the financial management services provider;

173.27 (5) the shared services that must be provided;

173.28 (6) the schedule for shared services;

173.29 (7) the location where shared services must be provided;

173.30 (8) the training specific to each individual served;

174.1 (9) the training specific to providing shared services to the individuals identified in the
174.2 agreement;

174.3 (10) instructions to follow all required documentation for time and services provided;

174.4 (11) a contingency plan for each of the individuals that accounts for service provision
174.5 and billing in the absence of one of the individuals in a shared services setting due to illness
174.6 or other circumstances;

174.7 (12) signatures of all parties involved in the shared services; and

174.8 (13) agreement by each of the individuals who are sharing services on the number of
174.9 shared hours for services provided.

174.10 (g) Any individual or any individual's representative may withdraw from participating
174.11 in a shared services agreement at any time.

174.12 (h) The lead agency for each individual must authorize the use of the shared services
174.13 option based on the criteria that the shared service is appropriate to meet the needs, health,
174.14 and safety of each individual for whom they provide case management or care coordination.

174.15 (i) Nothing in this subdivision must be construed to reduce the total authorized
174.16 consumer-directed community supports budget for an individual.

174.17 (j) No later than September 30, 2019, the commissioner of human services shall:

174.18 (1) submit an amendment to the Centers for Medicare and Medicaid Services for the
174.19 home and community-based services waivers authorized under Minnesota Statutes, sections
174.20 256B.092 and 256B.49, to allow for a shared services option under consumer-directed
174.21 community supports; and

174.22 (2) with stakeholder input, develop guidance for shared services in consumer-directed
174.23 community-supports within the Community Based Services Manual. Guidance must include:

174.24 (i) recommendations for negotiating payment for one-to-two and one-to-three services;
174.25 and

174.26 (ii) a template of the shared services agreement.

174.27 **EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval,
174.28 whichever is later, except for subdivision 2, paragraph (j), which is effective the day
174.29 following final enactment. The commissioner of human services shall notify the revisor of
174.30 statutes when federal approval is obtained.

175.1 Sec. 56. DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE
175.2 SYSTEM TRANSITION GRANTS.

175.3 (a) The commissioner of human services shall establish annual grants to day training
175.4 and habilitation providers that are projected to experience a funding gap upon the full
175.5 implementation of Minnesota Statutes, section 256B.4914.

175.6 (b) In order to be eligible for a grant under this section, a day training and habilitation
175.7 disability waiver provider must:

175.8 (1) serve at least 100 waiver service participants;

175.9 (2) be projected to receive a reduction in annual revenue from medical assistance for
175.10 day services during the first year of full implementation of disability waiver rate system
175.11 framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and
175.12 at least \$300,000 compared to the annual medical assistance revenue for day services the
175.13 provider received during the last full year during which banded rates under Minnesota
175.14 Statutes, section 256B.4913, subdivision 4a, were effective; and

175.15 (3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

175.16 (c) A recipient of a grant under this section must develop a sustainability plan in
175.17 partnership with the commissioner of human services. The sustainability plan must include:

175.18 (1) a review of all the provider's costs and an assessment of whether the provider is
175.19 implementing available cost-control options appropriately;

175.20 (2) a review of all the provider's revenue and an assessment of whether the provider is
175.21 leveraging available resources appropriately; and

175.22 (3) a practical strategy for closing the funding gap described in paragraph (b), clause
175.23 (2).

175.24 (d) The commissioner of human services shall provide technical assistance and financial
175.25 management advice to grant recipients as they develop and implement their sustainability
175.26 plans.

175.27 (e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate
175.28 to the commissioner of human services that it made a good faith effort to close the revenue
175.29 gap described in paragraph (b), clause (2).

176.1 **Sec. 57. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
176.2 **MNCHOICES 2.0.**

176.3 (a) The commissioner of human services must ensure that the MnCHOICES 2.0
176.4 assessment and support planning tool incorporates a qualitative approach with open-ended
176.5 questions and a conversational, culturally sensitive approach to interviewing that captures
176.6 the assessor's professional judgment based on the person's responses.

176.7 (b) If the commissioner of human services convenes a working group or consults with
176.8 stakeholders for the purposes of modifying the assessment and support planning process or
176.9 tool, the commissioner must include members of the disability community, including
176.10 representatives of organizations and individuals involved in assessment and support planning.

176.11 (c) Until MnCHOICES 2.0 is fully implemented, the commissioner shall permit counties
176.12 to use the most recent legacy documents related to long-term service and supports
176.13 assessments and shall reimburse counties in the same amount as the commissioner would
176.14 were the county using the MnCHOICES assessment tool.

176.15 **Sec. 58. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
176.16 **CAPITATION PAYMENTS FOR LONG-TERM SERVICES AND SUPPORTS**
176.17 **ASSESSMENT ACTIVITIES.**

176.18 By December 1, 2019, the commissioner of human services shall provide a report to the
176.19 chairs and ranking minority members of the legislative committees with jurisdiction over
176.20 human services finance and policy proposing a rate per assessment to be paid to counties
176.21 and tribes for all medical assistance and county human services activities currently reimbursed
176.22 via a random moment time study. The commissioner, in developing the proposal, shall use
176.23 past estimates of time spent on each relevant activity. The commissioner's report shall
176.24 include an explanation of how the commissioner determines the portion of capitated rates
176.25 paid to health plans attributable to each type of activity also performed by a county or tribe.
176.26 The commissioner's proposal must include a single rate per activity for each activity for all
176.27 populations, but may also include an alternative proposal for different rates per activity for
176.28 each activity for different populations.

176.29 **Sec. 59. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
176.30 **BARRIERS TO INDEPENDENT LIVING.**

176.31 By December 1, 2019, the commissioner of human services shall submit to the chairs
176.32 and ranking minority members of the legislative committees with jurisdiction over human
176.33 services finance and policy a report describing state and federal regulatory barriers, including

177.1 provisions of the Fair Housing Act, that create barriers to independent living for persons
 177.2 with disabilities. In developing the report, the commissioner shall consult with stakeholders,
 177.3 including individuals with disabilities, advocacy organizations, and service providers.

177.4 Sec. 60. **ADULT FOSTER CARE MORATORIUM EXEMPTION.**

177.5 An adult foster care setting located in Elk River, Sherburne County, and licensed in
 177.6 2003 to serve four people is exempt from the moratorium under Minnesota Statutes, section
 177.7 245A.03, subdivision 7, until July 1, 2020.

177.8 **EFFECTIVE DATE.** This section is effective July 1, 2019.

177.9 Sec. 61. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
 177.10 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
 177.11 **COUNTY.**

177.12 (a) The commissioner of human services shall allow a housing with services establishment
 177.13 located in Minneapolis that provides customized living and 24-hour customized living
 177.14 services for clients enrolled in the brain injury (BI) or community access for disability
 177.15 inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer
 177.16 service capacity of up to 66 clients to no more than three new housing with services
 177.17 establishments located in Hennepin County.

177.18 (b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall
 177.19 determine that the new housing with services establishments described under paragraph (a)
 177.20 meet the BI and CADI waiver customized living and 24-hour customized living size
 177.21 limitation exception for clients receiving those services at the new housing with services
 177.22 establishments described under paragraph (a).

177.23 Sec. 62. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 177.24 **PERSONAL CARE ASSISTANCE SERVICES COMPARABILITY WAIVER.**

177.25 The commissioner of human services shall submit by July 1, 2019, a waiver request to
 177.26 the Centers for Medicare and Medicaid Services to allow people receiving personal care
 177.27 assistance services as of December 31, 2019, to continue their eligibility for personal care
 177.28 assistance services under the personal care assistance service eligibility criteria in effect on
 177.29 December 31, 2019.

178.1 **Sec. 63. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
178.2 **TRANSITION PERIOD FOR MODIFIED ELIGIBILITY OF PERSONAL CARE**
178.3 **ASSISTANCE.**

178.4 (a) Beginning at the latest date permissible under federal law, the modified eligibility
178.5 criteria under Minnesota Statutes, section 256B.0625, subdivision 19a, and Minnesota
178.6 Statutes, section 256B.0652, subdivision 6, paragraphs (b) and (d), shall apply on a rolling
178.7 basis, at the time of annual assessments, to people receiving personal care assistance as of
178.8 December 31, 2019.

178.9 (b) The commissioner shall establish a transition period for people receiving personal
178.10 care assistance services as of December 31, 2019, who, at the time of the annual assessment
178.11 described in paragraph (a), are determined to be ineligible for personal care assistance
178.12 services. Service authorizations for this transition period shall not exceed one year.

178.13 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
178.14 whichever is later. The commissioner shall notify the revisor of statutes when federal
178.15 approval is obtained and when personal care assistance services provided under paragraph
178.16 (b) have expired.

178.17 **Sec. 64. DIRECTION TO THE COMMISSIONER; REPORT ON ELIGIBILITY**
178.18 **FOR PERSONAL CARE ASSISTANCE AND ACCESS TO DEVELOPMENTAL**
178.19 **DISABILITIES AND COMMUNITY ACCESS FOR DISABILITY INCLUSION**
178.20 **WAIVERS.**

178.21 By December 15, 2020, the commissioner shall submit a report to chairs and ranking
178.22 minority members of the legislative committees with jurisdiction over human services on
178.23 modifications to the eligibility criteria for the personal care assistance program and limits
178.24 on the growth of the developmental disabilities and community access for disability inclusion
178.25 waivers enacted following the 2019 legislative session. The report shall include the impact
178.26 on people receiving or requesting services and any recommendations. By February 15, 2021,
178.27 the commissioner shall supplement the December 15, 2020, report with updated data and
178.28 information.

178.29 **Sec. 65. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
178.30 **INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL**
178.31 **DISABILITIES LEVEL OF CARE CRITERIA.**

178.32 By February 1, 2020, the commissioner of human services shall submit to the chairs and
178.33 ranking minority members of the legislative committees with jurisdiction over health and

179.1 human services finance and policy recommended language to codify in Minnesota Statutes
179.2 the commissioner's existing criteria for the determination of need for intermediate care
179.3 facility for persons with developmental disabilities level of care. The recommended language
179.4 shall include language clarifying "at risk of placement," "reasonable indication," and "might
179.5 require" as those expressions are used in Minnesota Statutes, section 256B.092, subdivision
179.6 7, paragraph (b). The recommended statutory language shall also include the commissioner's
179.7 current guidance with respect to the interpretation and application of the federal standard
179.8 under Code of Federal Regulations, title 42, section 483.440, that a person receiving the
179.9 services of an intermediate care facility for persons with developmental disabilities require
179.10 a continuous active treatment plan, including which characteristics are necessary or sufficient
179.11 for a determination of a need for active treatment. The commissioner shall submit the
179.12 recommended statutory language with a letter listing, with statutory references, all the
179.13 programs and services for which an intermediate care facility for persons with developmental
179.14 disabilities level of care is required.

179.15 **Sec. 66. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
179.16 **DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

179.17 The commissioner of human services, in consultation with stakeholders, shall evaluate
179.18 the feasibility of developing a rate methodology for the personal care assistance program
179.19 under Minnesota Statutes, section 256B.0659, and community first services and supports
179.20 under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system
179.21 under Minnesota Statutes, section 256B.4914, including determining the component values
179.22 and factors to include in such a rate methodology; consider aligning any rate methodology
179.23 with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,
179.24 section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct
179.25 care workers; develop methods and determine the necessary resources for the commissioner
179.26 to more consistently collect and audit data from the direct care industry; and report
179.27 recommendations, including proposed draft legislation, to the chairs and ranking minority
179.28 members of the legislative committees with jurisdiction over human services policy and
179.29 finance by February 1, 2020.

179.30 **Sec. 67. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; HOME**
179.31 **CARE SERVICES PAYMENT REFORM PROPOSAL.**

179.32 The commissioner of human services shall submit to the chairs and ranking minority
179.33 members of the legislative committees with jurisdiction over human services finance and
179.34 policy a proposal to adopt a budget-neutral prospective payment system for nursing services

180.1 and home health services under Minnesota Statutes, sections 256B.0625, subdivision 6a,
180.2 and 256B.0653, and home care nursing services under Minnesota Statutes, sections
180.3 256B.0625, subdivision 7, and 256B.0624, modeled on the Medicare fee-for-service home
180.4 health prospective payment system. The commissioner shall include in the proposal a case
180.5 mix adjusted episodic rate, including services, therapies and supplies, minimum visits
180.6 required for an episodic rate, consolidated billing requirements, outlier payments,
180.7 low-utilization payments, and other criteria at the commissioner's discretion. In addition to
180.8 the budget-neutral payment reform proposal, the commissioner shall also submit a proposed
180.9 mechanism for updating the payment rates to reflect inflation in health care costs.

180.10 Sec. 68. **REVISOR INSTRUCTION.**

180.11 (a) The revisor of statutes shall change the term "developmental disability waiver" or
180.12 similar terms to "developmental disabilities waiver" or similar terms wherever they appear
180.13 in Minnesota Statutes. The revisor shall also make technical and other necessary changes
180.14 to sentence structure to preserve the meaning of the text.

180.15 (b) The revisor of statutes, in consultation with the House Research Department, Office
180.16 of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
180.17 prepare legislation for the 2020 legislative session to codify existing session laws governing
180.18 consumer-directed community supports in Minnesota Statutes, chapter 256B.

180.19 Sec. 69. **REPEALER.**

180.20 Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.

180.21

ARTICLE 6

180.22

DIRECT CARE AND TREATMENT

180.23 Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision
180.24 to read:

180.25 Subd. 3. **Administrative review of county liability for cost of care.** (a) The county of
180.26 financial responsibility may submit a written request for administrative review by the
180.27 commissioner of the county's payment of the cost of care when a delay in discharge of a
180.28 client from a regional treatment center, state-operated community-based behavioral health
180.29 hospital, or other state-operated facility results from the following actions by the facility:

180.30 (1) the facility did not provide notice to the county that the facility has determined that
180.31 it is clinically appropriate for a client to be discharged;

181.1 (2) the notice to the county that the facility has determined that it is clinically appropriate
181.2 for a client to be discharged was communicated on a holiday or weekend;

181.3 (3) the required documentation or procedures for discharge were not completed in order
181.4 for the discharge to occur in a timely manner; or

181.5 (4) the facility disagrees with the county's discharge plan.

181.6 (b) The county of financial responsibility may not appeal the determination that it is
181.7 clinically appropriate for a client to be discharged from a regional treatment center,
181.8 state-operated community-based behavioral health hospital, or other state-operated facility.

181.9 (c) The commissioner must evaluate the request for administrative review and determine
181.10 if the facility's actions listed in paragraph (a) caused undue delay in discharging the client.
181.11 If the commissioner determines that the facility's actions listed in paragraph (a) caused
181.12 undue delay in discharging the client, the county's liability will be reduced to the level of
181.13 the cost of care for a client whose stay in a facility is determined to be clinically appropriate,
181.14 effective on the date of the facility's action or failure to act that caused the delay. The
181.15 commissioner's determination under this subdivision is final.

181.16 (d) If a county's liability is reduced pursuant to paragraph (c), a county's liability will
181.17 return to the level of the cost of care for a client whose stay in a facility is determined to no
181.18 longer be appropriate effective on the date the facility rectifies the action or failure to act
181.19 that caused the delay under paragraph (a).

181.20 (e) Any difference in the county cost of care liability resulting from administrative review
181.21 under this subdivision shall not be billed to the client or applied to future reimbursement
181.22 from the client's estate or relatives.

181.23 **Sec. 2. DIRECTION TO COMMISSIONER; REPORT REQUIRED; DISCHARGE**
181.24 **DELAY REDUCTION.**

181.25 No later than January 1, 2023, the commissioner of human services must submit a report
181.26 to the chairs and ranking minority members of the legislative committees with jurisdiction
181.27 over human services that provides an update on county and state efforts to reduce the number
181.28 of days clients spend in state-operated facilities after discharge from the facility has been
181.29 determined to be clinically appropriate. The report must also include information on the
181.30 fiscal impact of clinically inappropriate stays in these facilities.

182.1 Sec. 3. **DIRECTION TO COMMISSIONER; MSOCS COON RAPIDS ILEX**
 182.2 **CLOSURE.**

182.3 The commissioner of human services shall close the Minnesota state-operated community
 182.4 services program known as MSOCS Coon Rapids Ilex. The commissioner must not reopen
 182.5 or redesign the program. For the purposes of this section:

182.6 (1) a program is considered closed if the commissioner discontinues providing services
 182.7 at a given location;

182.8 (2) a program is considered reopened if the commissioner opens a new program or begins
 182.9 providing a new service at a location that was previously closed; and

182.10 (3) a program is considered redesigned if the commissioner does not change the nature
 182.11 of the services provided, but does change the focus of the population served by the program.

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

182.13 Sec. 4. **REPEALER.**

182.14 Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

182.15 **ARTICLE 7**
 182.16 **OPERATIONS**

182.17 Section 1. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

182.18 Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide
 182.19 reconsideration requests, including the granting of variances, in accordance with the
 182.20 procedures and criteria contained in chapter 245C. The commissioner must set aside a
 182.21 disqualification for an individual who requests reconsideration and who meets the criteria
 182.22 described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision
 182.23 shall be provided to the individual and to the Department of Human Services. The
 182.24 commissioner's decision to grant or deny a reconsideration of disqualification is the final
 182.25 administrative agency action, except for the provisions under sections 245C.25, 245C.27,
 182.26 and 245C.28, subdivision 3.

182.27 Sec. 2. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

182.28 Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that
 182.29 the program complies with all applicable rules and laws, the commissioner shall issue a

183.1 license consistent with this section or, if applicable, a temporary change of ownership license
 183.2 under section 245A.043. At minimum, the license shall state:

183.3 (1) the name of the license holder;

183.4 (2) the address of the program;

183.5 (3) the effective date and expiration date of the license;

183.6 (4) the type of license;

183.7 (5) the maximum number and ages of persons that may receive services from the program;

183.8 and

183.9 (6) any special conditions of licensure.

183.10 (b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years

183.11 if:

183.12 (1) the commissioner is unable to conduct the evaluation or observation required by
 183.13 subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

183.14 (2) certain records and documents are not available because persons are not yet receiving
 183.15 services from the program; and

183.16 (3) the applicant complies with applicable laws and rules in all other respects.

183.17 (c) A decision by the commissioner to issue a license does not guarantee that any person

183.18 or persons will be placed or cared for in the licensed program. ~~A license shall not be~~

183.19 ~~transferable to another individual, corporation, partnership, voluntary association, other~~

183.20 ~~organization, or controlling individual or to another location.~~

183.21 ~~(d) A license holder must notify the commissioner and obtain the commissioner's approval~~

183.22 ~~before making any changes that would alter the license information listed under paragraph~~

183.23 ~~(a).~~

183.24 ~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not

183.25 issue or reissue a license if the applicant, license holder, or controlling individual has:

183.26 (1) been disqualified and the disqualification was not set aside and no variance has been
 183.27 granted;

183.28 (2) been denied a license within the past two years;

183.29 (3) had a license issued under this chapter revoked within the past five years;

184.1 (4) an outstanding debt related to a license fee, licensing fine, or settlement agreement
184.2 for which payment is delinquent; or

184.3 (5) failed to submit the information required of an applicant under subdivision 1,
184.4 paragraph (f) or (g), after being requested by the commissioner.

184.5 When a license issued under this chapter is revoked under clause (1) or (3), the license
184.6 holder and controlling individual may not hold any license under chapter 245A or 245D for
184.7 five years following the revocation, and other licenses held by the applicant, license holder,
184.8 or controlling individual shall also be revoked.

184.9 ~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an
184.10 individual living in the household where the licensed services will be provided as specified
184.11 under section 245C.03, subdivision 1, has been disqualified and the disqualification has not
184.12 been set aside and no variance has been granted.

184.13 ~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued
184.14 under this chapter has been suspended or revoked and the suspension or revocation is under
184.15 appeal, the program may continue to operate pending a final order from the commissioner.
184.16 If the license under suspension or revocation will expire before a final order is issued, a
184.17 temporary provisional license may be issued provided any applicable license fee is paid
184.18 before the temporary provisional license is issued.

184.19 ~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the
184.20 disqualification of a controlling individual or license holder, and the controlling individual
184.21 or license holder is ordered under section 245C.17 to be immediately removed from direct
184.22 contact with persons receiving services or is ordered to be under continuous, direct
184.23 supervision when providing direct contact services, the program may continue to operate
184.24 only if the program complies with the order and submits documentation demonstrating
184.25 compliance with the order. If the disqualified individual fails to submit a timely request for
184.26 reconsideration, or if the disqualification is not set aside and no variance is granted, the
184.27 order to immediately remove the individual from direct contact or to be under continuous,
184.28 direct supervision remains in effect pending the outcome of a hearing and final order from
184.29 the commissioner.

184.30 ~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care
184.31 Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A,
184.32 part 226, relocation within the same county by a licensed family day care provider, shall
184.33 be considered an extension of the license for a period of no more than 30 calendar days or

185.1 until the new license is issued, whichever occurs first, provided the county agency has
185.2 determined the family day care provider meets licensure requirements at the new location.

185.3 ~~(i)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire
185.4 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must
185.5 apply for and be granted a new license to operate the program or the program must not be
185.6 operated after the expiration date.

185.7 ~~(j)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has
185.8 been determined that a tribal licensing authority has established jurisdiction to license the
185.9 program or service.

185.10 **EFFECTIVE DATE.** This section is effective January 1, 2020.

185.11 Sec. 3. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to
185.12 read:

185.13 **Subd. 7a. Notification required.** (a) A license holder must notify the commissioner and
185.14 obtain the commissioner's approval before making any change that would alter the license
185.15 information listed under subdivision 7, paragraph (a).

185.16 (b) At least 30 days before the effective date of a change, the license holder must notify
185.17 the commissioner in writing of any change:

185.18 (1) to the license holder's controlling individual as defined in section 245A.02, subdivision
185.19 5a;

185.20 (2) to license holder information on file with the secretary of state;

185.21 (3) in the location of the program or service licensed under this chapter; and

185.22 (4) in the federal or state tax identification number associated with the license holder.

185.23 (c) When a license holder notifies the commissioner of a change to the business structure
185.24 governing the licensed program or services but is not selling the business, the license holder
185.25 must provide amended articles of incorporation and other documentation of the change and
185.26 any other information requested by the commissioner.

185.27 **EFFECTIVE DATE.** This section is effective January 1, 2020.

186.1 Sec. 4. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

186.2 Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid
186.3 for a premises and individual, organization, or government entity identified by the
186.4 commissioner on the license. A license is not transferable or assignable.

186.5 Subd. 2. **Change of ownership.** If the commissioner determines that there will be a
186.6 change of ownership, the commissioner shall require submission of a new license application.
186.7 A change of ownership occurs when:

186.8 (1) the license holder sells or transfers 100 percent of the property, stock, or assets;

186.9 (2) the license holder merges with another organization;

186.10 (3) the license holder consolidates with two or more organizations, resulting in the
186.11 creation of a new organization;

186.12 (4) there is a change in the federal tax identification number associated with the license
186.13 holder; or

186.14 (5) there is a turnover of each controlling individual associated with the license within
186.15 a 12-month period. A change to the license holder's controlling individuals, including a
186.16 change due to a transfer of stock, is not a change of ownership if at least one controlling
186.17 individual who was listed on the license for at least 12 consecutive months continues to be
186.18 a controlling individual after the reported change.

186.19 Subd. 3. **Change of ownership requirements.** (a) A license holder who intends to
186.20 change the ownership of the program or service under subdivision 2 to a party that intends
186.21 to assume operation without an interruption in service longer than 60 days after acquiring
186.22 the program or service must provide the commissioner with written notice of the proposed
186.23 sale or change, on a form provided by the commissioner, at least 60 days before the
186.24 anticipated date of the change in ownership. For purposes of this subdivision and subdivision
186.25 4, "party" means the party that intends to operate the service or program.

186.26 (b) The party must submit a license application under this chapter on the form and in
186.27 the manner prescribed by the commissioner at least 30 days before the change of ownership
186.28 is complete and must include documentation to support the upcoming change. The form
186.29 and manner of the application prescribed by the commissioner shall require only information
186.30 which is specifically required by statute or rule. The party must comply with background
186.31 study requirements under chapter 245C and shall pay the application fee required in section
186.32 245A.10. A party that intends to assume operation without an interruption in service longer

187.1 than 60 days after acquiring the program or service is exempt from the requirements of
187.2 Minnesota Rules, part 9530.6800.

187.3 (c) The commissioner may develop streamlined application procedures when the party
187.4 is an existing license holder under this chapter and is acquiring a program licensed under
187.5 this chapter or service in the same service class as one or more licensed programs or services
187.6 the party operates and those licenses are in substantial compliance according to the licensing
187.7 standards in this chapter and applicable rules. For purposes of this subdivision, "substantial
187.8 compliance" means within the past 12 months the commissioner did not: (i) issue a sanction
187.9 under section 245A.07 against a license held by the party or (ii) make a license held by the
187.10 party conditional according to section 245A.06.

187.11 (d) Except when a temporary change of ownership license is issued pursuant to
187.12 subdivision 4, the existing license holder is solely responsible for operating the program
187.13 according to applicable rules and statutes until a license under this chapter is issued to the
187.14 party.

187.15 (e) If a licensing inspection of the program or service was conducted within the previous
187.16 12 months and the existing license holder's license record demonstrates substantial
187.17 compliance with the applicable licensing requirements, the commissioner may waive the
187.18 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
187.19 commissioner proof that the premises was inspected by a fire marshal or that the fire marshal
187.20 deemed that an inspection was not warranted and proof that the premises was inspected for
187.21 compliance with the building code or that no inspection was deemed warranted.

187.22 (f) If the party is seeking a license for a program or service that has an outstanding
187.23 correction order, the party must submit a letter with the license application identifying how
187.24 and within what length of time the party shall resolve the outstanding correction order and
187.25 come into full compliance with the licensing requirements.

187.26 (g) Any action taken under section 245A.06 or 245A.07 against the existing license
187.27 holder's license at the time the party is applying for a license, including when the existing
187.28 license holder is operating under a conditional license or is subject to a revocation, shall
187.29 remain in effect until the commissioner determines that the grounds for the action are
187.30 corrected or no longer exist.

187.31 (h) The commissioner shall evaluate the application of the party according to section
187.32 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner
187.33 determines that the party complies with applicable laws and rules, the commissioner may
187.34 issue a license or a temporary change of ownership license.

188.1 (i) The commissioner may deny an application as provided in section 245A.05. An
188.2 applicant whose application was denied by the commissioner may appeal the denial according
188.3 to section 245A.05.

188.4 (j) This subdivision does not apply to a licensed program or service located in a home
188.5 where the license holder resides.

188.6 **Subd. 4. Temporary change of ownership license.** (a) After receiving the party's
188.7 application and upon the written request of the existing license holder and the party, the
188.8 commissioner may issue a temporary change of ownership license to the party while the
188.9 commissioner evaluates the party's application. Until a decision is made to grant or deny a
188.10 license under this chapter, the existing license holder and the party shall both be responsible
188.11 for operating the program or service according to applicable laws and rules, and the sale or
188.12 transfer of the license holder's ownership interest in the licensed program or service does
188.13 not terminate the existing license.

188.14 (b) The commissioner may establish criteria to issue a temporary change of ownership
188.15 license, if a license holder's death, divorce, or other event affects the ownership of the
188.16 program, when an applicant seeks to assume operation of the program or service to ensure
188.17 continuity of the program or service while a license application is evaluated. This subdivision
188.18 applies to any program or service licensed under this chapter.

188.19 **EFFECTIVE DATE.** This section is effective January 1, 2020.

188.20 Sec. 5. Minnesota Statutes 2018, section 245A.065, is amended to read:

188.21 **245A.065 CHILD CARE FIX-IT TICKET.**

188.22 **Subdivision 1. Contents of fix-it tickets.** (a) In lieu of a correction order under section
188.23 245A.06, the commissioner shall ~~may~~ issue a fix-it ticket to a family child care or child care
188.24 center license holder if the commissioner finds that:

188.25 (1) the license holder has failed to comply with a requirement in this chapter or Minnesota
188.26 Rules, chapter 9502 or 9503, ~~that the commissioner determines to be eligible for a fix-it~~
188.27 ~~ticket;~~

188.28 (2) the violation does not imminently endanger the health, safety, or rights of the persons
188.29 served by the program;

188.30 (3) the license holder did not receive a fix-it ticket or correction order for the violation
188.31 at the license holder's last licensing inspection; and

189.1 (4) the violation ~~can~~ cannot be corrected at the time of inspection ~~or within 48 hours,~~
 189.2 ~~excluding Saturdays, Sundays, and holidays; and~~

189.3 ~~(5) the license holder corrects the violation at the time of inspection or agrees to correct~~
 189.4 ~~the violation within 48 hours, excluding Saturdays, Sundays, and holidays.~~

189.5 (b) The commissioner shall not issue a fix-it ticket for violations that are corrected at
 189.6 the time of the inspection.

189.7 (c) The fix-it ticket must state:

189.8 (1) the conditions that constitute a violation of the law or rule;

189.9 (2) the specific law or rule violated; and

189.10 (3) that the violation ~~was corrected at the time of inspection or~~ must be corrected within
 189.11 48 hours, excluding Saturdays, Sundays, and holidays.

189.12 ~~(e)~~ (d) The commissioner shall not publicly publish a fix-it ticket on the department's
 189.13 website.

189.14 ~~(d)~~ (e) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it
 189.15 ticket, the license holder must correct the violation and within one week submit evidence
 189.16 to the licensing agency that the violation was corrected.

189.17 ~~(e)~~ (f) If the violation is not corrected ~~at the time of inspection or~~ within 48 hours,
 189.18 excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to
 189.19 establish that the license holder corrected the violation, the commissioner must issue a
 189.20 correction order, according to section 245A.06, for the violation of Minnesota law or rule
 189.21 identified in the fix-it ticket ~~according to section 245A.06~~.

189.22 ~~(f) The commissioner shall, following consultation with family child care license holders,~~
 189.23 ~~child care center license holders, and county agencies, issue a report by October 1, 2017,~~
 189.24 ~~that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503,~~
 189.25 ~~that are eligible for a fix-it ticket. The commissioner shall provide the report to county~~
 189.26 ~~agencies and the chairs and ranking minority members of the legislative committees with~~
 189.27 ~~jurisdiction over child care, and shall post the report to the department's website.~~

189.28 Subd. 2. Fix-it ticket laws and rules. (a) For family child care license holders, violations
 189.29 of the following laws and rules may qualify only for a fix-it ticket: 9502.0335, subpart 10;
 189.30 9502.0375, subpart 2; 9502.0395; 9502.0405, subpart 3; 9502.0405, subpart 4, item A;
 189.31 9502.0415, subpart 3; 9502.0425, subpart 2 (outdoor play spaces must be free from litter,
 189.32 rubbish, unlocked vehicles, or human or animal waste); 9502.0425, subpart 3 (wading pools

190.1 must be kept clean); 9502.0425, subpart 5; 9502.0425, subpart 7, item F (screens on exterior
 190.2 doors and windows when biting insects are prevalent); 9502.0425, subpart 8; 9502.0425,
 190.3 subpart 10; 9502.0425, subpart 11 (decks free of splinters); 9502.0425, subpart 13 (toilets
 190.4 flush thoroughly); 9502.0425, subpart 16; 9502.0435, subpart 1; 9502.0435, subpart 3;
 190.5 9502.0435, subpart 7; 9502.0435, subpart 8, item B; 9502.0435, subpart 8, item E; 9502.0435,
 190.6 subpart 12, items A through E; 9502.0435, subpart 13; 9502.0435, subpart 14; 9502.0435,
 190.7 subpart 15; 9502.0435, subpart 15, items A and B; 9502.0445, subpart 1, item B; 9502.0445,
 190.8 subpart 3, items B through D; 9502.0445, subpart 4, items A through C; 245A.04, subdivision
 190.9 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.146, subdivision
 190.10 3, paragraph (c); 245A.148; 245A.152; 245A.50, subdivision 7; 245A.51, subdivision 3,
 190.11 paragraph (d) (emergency preparedness plan available for review and posted in prominent
 190.12 location).

190.13 (b) For child care center license holders, violations of the following laws and rules may
 190.14 qualify only for a fix-it ticket: 9503.0120, item B; 9503.0120, item E; 9503.0125, item E;
 190.15 9503.0125, item F; 9503.0125, item I; 9503.0125, item M; 9503.0140, subpart 2; 9503.0140,
 190.16 subpart 7, item D; 9503.0140, subpart 9; 9503.0140, subpart 10; 9503.0140, subpart 13;
 190.17 9503.0140, subpart 14; 9503.0140, subpart 15; 9503.0140, subpart 16 (item missing from
 190.18 first-aid kit); 9503.0140, subpart 18; 9503.0140, subpart 19; 9503.0140, subpart 20;
 190.19 9503.0140, subpart 21 (emergency plan not posted in prominent place); 9503.0145, subpart
 190.20 2; 9503.0145, subpart 3; 9503.0145, subpart 4, item D; 9503.0145, subpart 8 (drinking water
 190.21 provided in single service cups or at an accessible drinking fountain); 9503.0155, subpart
 190.22 7, item D; 9503.0155, subpart 13; 9503.0155, subpart 16; 9503.0155, subpart 17; 9503.0155,
 190.23 subpart 18, item D; 9503.0170, subpart 3; 9503.0145, subpart 7, item D; 245A.04, subdivision
 190.24 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.14, subdivision
 190.25 8, paragraph (b) (experienced aide identification posting); 245A.146, subdivision 3, paragraph
 190.26 (c); 245A.152; 245A.41, subdivision 3, paragraph (d); 245A.41, subdivision 3, paragraph
 190.27 (e); 245A.41, subdivision 3, paragraph (f).

190.28 Sec. 6. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to
 190.29 read:

190.30 Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment
 190.31 field" means a program exclusively serving individuals 18 years of age and older and that
 190.32 is required to be:

190.33 (1) licensed under chapter 245G; or

191.1 (2) registered under section 157.17 as a board and lodge establishment that predominantly
191.2 serves individuals being treated for or recovering from a substance use disorder.

191.3 Sec. 7. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

191.4 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification
191.5 if the commissioner finds that the individual has submitted sufficient information to
191.6 demonstrate that the individual does not pose a risk of harm to any person served by the
191.7 applicant, license holder, or other entities as provided in this chapter.

191.8 (b) In determining whether the individual has met the burden of proof by demonstrating
191.9 the individual does not pose a risk of harm, the commissioner shall consider:

191.10 (1) the nature, severity, and consequences of the event or events that led to the
191.11 disqualification;

191.12 (2) whether there is more than one disqualifying event;

191.13 (3) the age and vulnerability of the victim at the time of the event;

191.14 (4) the harm suffered by the victim;

191.15 (5) vulnerability of persons served by the program;

191.16 (6) the similarity between the victim and persons served by the program;

191.17 (7) the time elapsed without a repeat of the same or similar event;

191.18 (8) documentation of successful completion by the individual studied of training or
191.19 rehabilitation pertinent to the event; and

191.20 (9) any other information relevant to reconsideration.

191.21 (c) If the individual requested reconsideration on the basis that the information relied
191.22 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines
191.23 that the information relied upon to disqualify the individual is correct, the commissioner
191.24 must also determine if the individual poses a risk of harm to persons receiving services in
191.25 accordance with paragraph (b).

191.26 (d) For an individual seeking employment in the substance use disorder treatment field,
191.27 the commissioner shall set aside the disqualification if the following criteria are met:

191.28 (1) the individual is not disqualified for a crime of violence as listed under section
191.29 624.712, subdivision 5, except that the following crimes are prohibitory offenses: crimes
191.30 listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023,
191.31 subdivision 2; 152.024; or 152.025;

- 192.1 (2) the individual is not disqualified under section 245C.15, subdivision 1;
- 192.2 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph
- 192.3 (b);
- 192.4 (4) the individual provided documentation of successful completion of treatment, at least
- 192.5 one year prior to the date of the request for reconsideration, at a program licensed under
- 192.6 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after
- 192.7 the successful completion of treatment;
- 192.8 (5) the individual provided documentation demonstrating abstinence from controlled
- 192.9 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to
- 192.10 the date of the request for reconsideration; and
- 192.11 (6) the individual is seeking employment in the substance use disorder treatment field.

192.12 Sec. 8. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

192.13 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under

192.14 this section, the disqualified individual remains disqualified, but may hold a license and

192.15 have direct contact with or access to persons receiving services. Except as provided in

192.16 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the

192.17 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.

192.18 For personal care provider organizations, the commissioner's set-aside may further be limited

192.19 to a specific individual who is receiving services. For new background studies required

192.20 under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was

192.21 previously set aside for the license holder's program and the new background study results

192.22 in no new information that indicates the individual may pose a risk of harm to persons

192.23 receiving services from the license holder, the previous set-aside shall remain in effect.

192.24 (b) If the commissioner has previously set aside an individual's disqualification for one

192.25 or more programs or agencies, and the individual is the subject of a subsequent background

192.26 study for a different program or agency, the commissioner shall determine whether the

192.27 disqualification is set aside for the program or agency that initiated the subsequent

192.28 background study. A notice of a set-aside under paragraph (c) shall be issued within 15

192.29 working days if all of the following criteria are met:

- 192.30 (1) the subsequent background study was initiated in connection with a program licensed
- 192.31 or regulated under the same provisions of law and rule for at least one program for which
- 192.32 the individual's disqualification was previously set aside by the commissioner;

193.1 (2) the individual is not disqualified for an offense specified in section 245C.15,
193.2 subdivision 1 or 2;

193.3 (3) the commissioner has received no new information to indicate that the individual
193.4 may pose a risk of harm to any person served by the program; and

193.5 (4) the previous set-aside was not limited to a specific person receiving services.

193.6 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the
193.7 substance use disorder field, if the commissioner has previously set aside an individual's
193.8 disqualification for one or more programs or agencies in the substance use disorder treatment
193.9 field, and the individual is the subject of a subsequent background study for a different
193.10 program or agency in the substance use disorder treatment field, the commissioner shall set
193.11 aside the disqualification for the program or agency in the substance use disorder treatment
193.12 field that initiated the subsequent background study when the criteria under paragraph (b),
193.13 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified
193.14 in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued
193.15 within 15 working days.

193.16 ~~(e)~~(d) When a disqualification is set aside under paragraph (b), the notice of background
193.17 study results issued under section 245C.17, in addition to the requirements under section
193.18 245C.17, shall state that the disqualification is set aside for the program or agency that
193.19 initiated the subsequent background study. The notice must inform the individual that the
193.20 individual may request reconsideration of the disqualification under section 245C.21 on the
193.21 basis that the information used to disqualify the individual is incorrect.

193.22 **Sec. 9. [256.0113] COUNTY HUMAN SERVICES STATE FUNDING**
193.23 **REALLOCATION.**

193.24 (a) Beginning October 1, 2019, counties and tribes or tribal agencies receiving human
193.25 services grants funded exclusively with state general fund dollars may allocate any
193.26 unexpended grant amounts to any county or tribal human services activity for the fourth
193.27 quarter of the county or tribe's fiscal year.

193.28 (b) Any proposed reallocation of unspent funds must be approved by majority vote of
193.29 the county board or the tribe or tribal agency's governing body.

193.30 (c) Each county, tribe, or tribal agency shall report any approved reallocation of unspent
193.31 grant funds to the commissioner of human services by March 31 of each year following a
193.32 reallocation under this section. The report shall describe the use of the reallocated human

194.1 services grant funds, compare how the funds were allocated prior to the reallocation, and
194.2 explain the advantages or disadvantages of the reallocation.

194.3 Sec. 10. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

194.4 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare
194.5 and Medicaid Services determines that a provider is designated "high-risk," the commissioner
194.6 may withhold payment from providers within that category upon initial enrollment for a
194.7 90-day period. The withholding for each provider must begin on the date of the first
194.8 submission of a claim.

194.9 (b) An enrolled provider that is also licensed by the commissioner under chapter 245A,
194.10 or is licensed as a home care provider by the Department of Health under chapter 144A and
194.11 has a home and community-based services designation on the home care license under
194.12 section 144A.484, must designate an individual as the entity's compliance officer. The
194.13 compliance officer must:

194.14 (1) develop policies and procedures to assure adherence to medical assistance laws and
194.15 regulations and to prevent inappropriate claims submissions;

194.16 (2) train the employees of the provider entity, and any agents or subcontractors of the
194.17 provider entity including billers, on the policies and procedures under clause (1);

194.18 (3) respond to allegations of improper conduct related to the provision or billing of
194.19 medical assistance services, and implement action to remediate any resulting problems;

194.20 (4) use evaluation techniques to monitor compliance with medical assistance laws and
194.21 regulations;

194.22 (5) promptly report to the commissioner any identified violations of medical assistance
194.23 laws or regulations; and

194.24 (6) within 60 days of discovery by the provider of a medical assistance reimbursement
194.25 overpayment, report the overpayment to the commissioner and make arrangements with
194.26 the commissioner for the commissioner's recovery of the overpayment.

194.27 The commissioner may require, as a condition of enrollment in medical assistance, that a
194.28 provider within a particular industry sector or category establish a compliance program that
194.29 contains the core elements established by the Centers for Medicare and Medicaid Services.

194.30 (c) The commissioner may revoke the enrollment of an ordering or rendering provider
194.31 for a period of not more than one year, if the provider fails to maintain and, upon request
194.32 from the commissioner, provide access to documentation relating to written orders or requests

195.1 for payment for durable medical equipment, certifications for home health services, or
195.2 referrals for other items or services written or ordered by such provider, when the
195.3 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
195.4 to maintain documentation or provide access to documentation on more than one occasion.
195.5 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
195.6 under the provisions of section 256B.064.

195.7 (d) The commissioner shall terminate or deny the enrollment of any individual or entity
195.8 if the individual or entity has been terminated from participation in Medicare or under the
195.9 Medicaid program or Children's Health Insurance Program of any other state. The
195.10 commissioner may exempt a rehabilitation agency from termination or denial that would
195.11 otherwise be required under this paragraph, if the agency:

195.12 (1) is unable to retain Medicare certification and enrollment solely due to a lack of billing
195.13 to the Medicare program;

195.14 (2) meets all other applicable Medicare certification requirements based on an on-site
195.15 review completed by the commissioner of health; and

195.16 (3) serves primarily a pediatric population.

195.17 (e) As a condition of enrollment in medical assistance, the commissioner shall require
195.18 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
195.19 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
195.20 Services, its agents, or its designated contractors and the state agency, its agents, or its
195.21 designated contractors to conduct unannounced on-site inspections of any provider location.
195.22 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
195.23 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
195.24 and standards used to designate Medicare providers in Code of Federal Regulations, title
195.25 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
195.26 The commissioner's designations are not subject to administrative appeal.

195.27 (f) As a condition of enrollment in medical assistance, the commissioner shall require
195.28 that a high-risk provider, or a person with a direct or indirect ownership interest in the
195.29 provider of five percent or higher, consent to criminal background checks, including
195.30 fingerprinting, when required to do so under state law or by a determination by the
195.31 commissioner or the Centers for Medicare and Medicaid Services that a provider is designated
195.32 high-risk for fraud, waste, or abuse.

195.33 (g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
195.34 medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers

196.1 meeting the durable medical equipment provider and supplier definition in clause (3),
196.2 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
196.3 annually renewed and designates the Minnesota Department of Human Services as the
196.4 obligee, and must be submitted in a form approved by the commissioner. For purposes of
196.5 this clause, the following medical suppliers are not required to obtain a surety bond: a
196.6 federally qualified health center, a home health agency, the Indian Health Service, a
196.7 pharmacy, and a rural health clinic.

196.8 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
196.9 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
196.10 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
196.11 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
196.12 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
196.13 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
196.14 fees in pursuing a claim on the bond.

196.15 (3) "Durable medical equipment provider or supplier" means a medical supplier that can
196.16 purchase medical equipment or supplies for sale or rental to the general public and is able
196.17 to perform or arrange for necessary repairs to and maintenance of equipment offered for
196.18 sale or rental.

196.19 (h) The Department of Human Services may require a provider to purchase a surety
196.20 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment
196.21 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
196.22 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
196.23 provider or category of providers is designated high-risk pursuant to paragraph (a) and as
196.24 per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an
196.25 amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
196.26 immediately preceding 12 months, whichever is greater. The surety bond must name the
196.27 Department of Human Services as an obligee and must allow for recovery of costs and fees
196.28 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
196.29 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

196.30 Sec. 11. **REPEALER.**

196.31 Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 245G.11, subdivisions
196.32 1, 4, and 7, are repealed.

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

197.1

ARTICLE 8

197.2

HEALTH CARE

197.3 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

197.4 Subdivision 1. **Classifications.** (a) The following government data of the Department
197.5 of Public Safety are private data:

197.6 (1) medical data on driving instructors, licensed drivers, and applicants for parking
197.7 certificates and special license plates issued to physically disabled persons;

197.8 (2) other data on holders of a disability certificate under section 169.345, except that (i)
197.9 data that are not medical data may be released to law enforcement agencies, and (ii) data
197.10 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
197.11 enforcement employees or parking enforcement agents of statutory or home rule charter
197.12 cities and towns;

197.13 (3) Social Security numbers in driver's license and motor vehicle registration records,
197.14 except that Social Security numbers must be provided to the Department of Revenue for
197.15 purposes of tax administration, the Department of Labor and Industry for purposes of
197.16 workers' compensation administration and enforcement, the judicial branch for purposes of
197.17 debt collection, and the Department of Natural Resources for purposes of license application
197.18 administration, and except that the last four digits of the Social Security number must be
197.19 provided to the Department of Human Services for purposes of recovery of Minnesota health
197.20 care program benefits paid; and

197.21 (4) data on persons listed as standby or temporary custodians under section 171.07,
197.22 subdivision 11, except that the data must be released to:

197.23 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
197.24 caregiver; or

197.25 (ii) law enforcement agencies who state that the license holder is unable to communicate
197.26 at that time and that the information is necessary for notifying the designated caregiver of
197.27 the need to care for a child of the license holder.

197.28 The department may release the Social Security number only as provided in clause (3)
197.29 and must not sell or otherwise provide individual Social Security numbers or lists of Social
197.30 Security numbers for any other purpose.

197.31 (b) The following government data of the Department of Public Safety are confidential
197.32 data: data concerning an individual's driving ability when that data is received from a member
197.33 of the individual's family.

198.1 Sec. 2. Minnesota Statutes 2018, section 256.9365, is amended to read:

198.2 **256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR**
 198.3 **~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.**

198.4 Subdivision 1. **Program established.** The commissioner of human services shall establish
 198.5 a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions,
 198.6 including co-payments, deductibles, and coinsurance for persons who have contracted human
 198.7 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
 198.8 group or individual health plan. If a person is determined to be eligible under subdivision
 198.9 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
 198.10 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
 198.11 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription
 198.12 cost sharing, including co-payments and deductibles required under section 256B.0631.
 198.13 The commissioner shall not pay for that portion of a premium that is attributable to other
 198.14 family members or dependents or is paid by the individual's employer.

198.15 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
 198.16 ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part
 198.17 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

198.18 ~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or~~
 198.19 ~~physician assistant's statement verifying that the applicant is infected with HIV and is, or~~
 198.20 ~~within three months is likely to become, too ill to work in the applicant's current employment~~
 198.21 ~~because of HIV-related disease;~~

198.22 ~~(2) the applicant's monthly gross family income must not exceed 300 percent of the~~
 198.23 ~~federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

198.24 ~~(3) the applicant must not own assets with a combined value of more than \$25,000; and~~

198.25 ~~(4) if applying for payment of group plan premiums, the applicant must be covered by~~
 198.26 ~~an employer's or former employer's group insurance plan.~~

198.27 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
 198.28 premiums under ~~subdivision 2, clause (5),~~ this section must be designed to ensure that the
 198.29 state cost of paying an individual plan premium does not exceed the estimated state cost
 198.30 that would otherwise be incurred in the medical assistance program. The commissioner
 198.31 shall purchase the most cost-effective coverage available for eligible individuals.

199.1 Sec. 3. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

199.2 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
199.3 assistance, a person must not individually own more than \$3,000 in assets, or if a member
199.4 of a household with two family members, husband and wife, or parent and child, the
199.5 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
199.6 dependent. In addition to these maximum amounts, an eligible individual or family may
199.7 accrue interest on these amounts, but they must be reduced to the maximum at the time of
199.8 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
199.9 according to section 256B.35 must also be reduced to the maximum at the time of the
199.10 eligibility redetermination. The value of assets that are not considered in determining
199.11 eligibility for medical assistance is the value of those assets excluded under the Supplemental
199.12 Security Income program for aged, blind, and disabled persons, with the following
199.13 exceptions:

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

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

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

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

199.23 (5) for a person who no longer qualifies as an employed person with a disability due to
199.24 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
199.25 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
199.26 as an employed person with a disability, to the extent that the person's total assets remain
199.27 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

199.28 ~~(6) when a person enrolled in medical assistance under section 256B.057, subdivision~~
199.29 ~~9, is age 65 or older and has been enrolled during each of the 24 consecutive months before~~
199.30 ~~the person's 65th birthday, the assets owned by the person and the person's spouse must be~~
199.31 ~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when~~
199.32 ~~determining eligibility for medical assistance under section 256B.055, subdivision 7. a~~
199.33 designated employment incentives asset account is disregarded when determining eligibility
199.34 for medical assistance for a person age 65 years or older under section 256B.055, subdivision

200.1 7. An employment incentives asset account must only be designated by a person who has
200.2 been enrolled in medical assistance under section 256B.057, subdivision 9, for a
200.3 24-consecutive-month period. A designated employment incentives asset account contains
200.4 qualified assets owned by the person and the person's spouse in the last month of enrollment
200.5 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
200.6 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
200.7 other nonexcluded assets. An employment incentives asset account is no longer designated
200.8 when a person loses medical assistance eligibility for a calendar month or more before
200.9 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
200.10 a new designated employment incentives asset account by establishing a new
200.11 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
200.12 income of a spouse of a person enrolled in medical assistance under section 256B.057,
200.13 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
200.14 must be disregarded when determining eligibility for medical assistance under section
200.15 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
200.16 in section 256B.059; and

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

200.21 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
200.22 15.

200.23 **EFFECTIVE DATE.** This section is effective July 1, 2019.

200.24 Sec. 4. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

200.25 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and
200.26 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard
200.27 specified in subdivision 4, paragraph (b).

200.28 (b) The excess income standard for a person whose eligibility is based on blindness,
200.29 disability, or age of 65 or more years shall equal ~~81~~ 82 percent of the federal poverty
200.30 guidelines. Effective July 1, 2021, the excess income standard for a person whose eligibility
200.31 is based on blindness disability, or age of 65 or more years, is the standard specified in
200.32 subdivision 4, paragraph (a).

200.33 **EFFECTIVE DATE.** This section is effective January 1, 2020.

201.1 Sec. 5. Minnesota Statutes 2018, section 256B.0625, subdivision 18d, is amended to read:

201.2 Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical
201.3 Transportation Advisory Committee consists of:

201.4 (1) four voting members who represent counties, utilizing the rural urban commuting
201.5 area classification system. As defined in subdivision 17, these members shall be designated
201.6 as follows:

201.7 (i) two counties within the 11-county metropolitan area;

201.8 (ii) one county representing the rural area of the state; and

201.9 (iii) one county representing the super rural area of the state.

201.10 The Association of Minnesota Counties shall appoint one county within the 11-county
201.11 metropolitan area and one county representing the super rural area of the state. The Minnesota
201.12 Inter-County Association shall appoint one county within the 11-county metropolitan area
201.13 and one county representing the rural area of the state;

201.14 (2) three voting members who represent medical assistance recipients, including persons
201.15 with physical and developmental disabilities, persons with mental illness, seniors, children,
201.16 and low-income individuals;

201.17 (3) ~~four~~ five voting members who represent providers that deliver nonemergency medical
201.18 transportation services to medical assistance enrollees, one of whom is a taxicab owner or
201.19 operator;

201.20 (4) two voting members of the house of representatives, one from the majority party and
201.21 one from the minority party, appointed by the speaker of the house, and two voting members
201.22 from the senate, one from the majority party and one from the minority party, appointed by
201.23 the Subcommittee on Committees of the Committee on Rules and Administration;

201.24 (5) one voting member who represents demonstration providers as defined in section
201.25 256B.69, subdivision 2;

201.26 (6) one voting member who represents an organization that contracts with state or local
201.27 governments to coordinate transportation services for medical assistance enrollees;

201.28 (7) one voting member who represents the Minnesota State Council on Disability;

201.29 (8) the commissioner of transportation or the commissioner's designee, who shall serve
201.30 as a voting member;

201.31 (9) one voting member appointed by the Minnesota Ambulance Association; and

202.1 (10) one voting member appointed by the Minnesota Hospital Association.

202.2 (b) Members of the advisory committee shall not be employed by the Department of
202.3 Human Services. Members of the advisory committee shall receive no compensation.

202.4 Sec. 6. **PAIN MANAGEMENT.**

202.5 (a) The Health Services Policy Committee established under Minnesota Statutes, section
202.6 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration
202.7 of nonpharmacologic pain management that are clinically viable and sustainable; reduce or
202.8 eliminate chronic pain conditions; improve functional status; and prevent addiction and
202.9 reduce dependence on opiates or other pain medications. The recommendations must be
202.10 based on best practices for the effective treatment of musculoskeletal pain provided by
202.11 health practitioners identified in paragraph (b), and covered under medical assistance. Each
202.12 health practitioner represented under paragraph (b) shall present the minimum best integrated
202.13 practice recommendations, policies, and scientific evidence for nonpharmacologic treatment
202.14 options for eliminating pain and improving functional status within their full professional
202.15 scope. Recommendations for integration of services may include guidance regarding
202.16 screening for co-occurring behavioral health diagnoses; protocols for communication between
202.17 all providers treating a unique individual, including protocols for follow-up; and universal
202.18 mechanisms to assess improvements in functional status.

202.19 (b) In evaluating and making recommendations, the Health Services Policy Committee
202.20 shall consult and collaborate with the following health practitioners: acupuncture practitioners
202.21 licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota
202.22 Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes,
202.23 sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota
202.24 Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota
202.25 Statutes, sections 148.171 to 148.285, with experience in providing primary care
202.26 collaboratively within a multidisciplinary team of health care practitioners who employ
202.27 nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes,
202.28 section 148.907.

202.29 (c) The commissioner shall submit a progress report to the chairs and ranking minority
202.30 members of the legislative committees with jurisdiction over health and human services
202.31 policy and finance by January 15, 2020, and shall report final recommendations by August
202.32 1, 2020. The final report may also contain recommendations for developing and implementing
202.33 a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated

203.1 nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and
 203.2 improving functional status.

203.3 **ARTICLE 9**

203.4 **APPROPRIATIONS**

203.5 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

203.6 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
 203.7 and for the purposes specified in this article. The appropriations are from the general fund,
 203.8 or another named fund, and are available for the fiscal years indicated for each purpose.

203.9 The figures "2020" and "2021" used in this article mean that the appropriations listed under
 203.10 them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively.
 203.11 "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium"
 203.12 is fiscal years 2020 and 2021.

203.13 **APPROPRIATIONS**

203.14 **Available for the Year**

203.15 **Ending June 30**

203.16 **2020**

2021

203.17 **Sec. 2. COMMISSIONER OF HUMAN**
 203.18 **SERVICES**

\$ (17,122,000) \$ (154,855,000)

203.19 **Appropriations by Fund**

203.20 **2020**

2021

203.21 **General** **(17,115,000)** **(155,846,000)**

203.22 **Health Care Access** **(7,000)** **(9,000)**

203.23 **Federal TANF** **-0-** **1,000,000**

203.24 **(a) Gun Violence Prevention Grants.**

203.25 **\$100,000 in fiscal year 2020 is from the**

203.26 **general fund for gun violence prevention**

203.27 **grants to nonprofit organizations with**

203.28 **expertise in gun violence prevention to**

203.29 **conduct gun violence prevention initiatives or**

203.30 **public awareness and education campaigns on**

203.31 **gun violence prevention. This is a onetime**

203.32 **appropriation.**

204.1 **(b) Semi-Independent Living Services**

204.2 **Grants.** \$1,000,000 in fiscal year 2020 and
204.3 \$1,000,000 in fiscal year 2021 are from the
204.4 general fund for reimbursement to lead
204.5 agencies under Minnesota Statutes, section
204.6 252.275.

204.7 **(c) Social Functioning Measurement Tool.**

204.8 \$100,000 in fiscal year 2020 is from the
204.9 general fund for the commissioner to
204.10 determine whether the Center for Victims of
204.11 Torture's social functioning measurement tool
204.12 can be adapted for other populations that
204.13 receive targeted case management and other
204.14 medical assistance services. This is a onetime
204.15 appropriation and is available until June 30,
204.16 2023.

204.17 **(d) Homeless Youth Drop-In Program**

204.18 **Grant.** Notwithstanding Minnesota Statutes,
204.19 section 16B.97, \$100,000 in fiscal year 2020
204.20 is from the general fund for a grant to an
204.21 organization in Anoka County providing
204.22 services and programming through a drop-in
204.23 program to meet the basic needs, including
204.24 mental health needs, of homeless youth in the
204.25 north metropolitan suburbs, to develop a
204.26 model of its homeless youth drop-in program
204.27 that can be shared and replicated in other
204.28 communities throughout Minnesota. This is a
204.29 onetime appropriation.

204.30 **(e) Pathways to Prosperity.** \$1,000,000 in

204.31 fiscal year 2021 is from the federal TANF
204.32 fund for the unified benefit amount of the
204.33 Minnesota Pathways to Prosperity and
204.34 Well-Being pilot project. The commissioner
204.35 may award the grant only upon issuance of

205.1 formal approval of the pilot project plan as
205.2 required under article ..., section ...,
205.3 subdivision 1, paragraph (c), and after
205.4 fulfillment of the condition in article ...,
205.5 section ..., subdivision 1, paragraph (b), clause
205.6 (3). No amount of the appropriation may be
205.7 used for any other purpose of the pilot project.
205.8 The base for this appropriation is \$1,000,000
205.9 in fiscal year 2022 and \$1,000,000 in fiscal
205.10 year 2023. This is not an ongoing
205.11 appropriation. The commissioner of
205.12 management and budget shall not include a
205.13 base amount for this appropriation in fiscal
205.14 year 2024. This section expires June 30, 2023.

205.15 **(f) Community-Based Housing and**
205.16 **Behavioral Health Services for Opiate**
205.17 **Addiction.** Notwithstanding Minnesota
205.18 Statutes, section 16B.97, \$25,000 in fiscal year
205.19 2020 and \$25,000 in fiscal year 2021 are from
205.20 the general fund for a grant to Oasis Central
205.21 Minnesota, Inc., serving Morrison County to
205.22 provide opioid programming, behavioral
205.23 health services, and residential housing with
205.24 employment services.

205.25 **(g) Parent-to-Parent Peer Support Grants.**
205.26 \$100,000 in fiscal year 2020 and \$100,000 in
205.27 fiscal year 2021 are from the general fund for
205.28 grants under Minnesota Statutes, section
205.29 256.4751.

205.30 **(h) Children's Mental Health Grant.**
205.31 Notwithstanding Minnesota Statutes, section
205.32 16B.97, \$193,000 in fiscal year 2020 is from
205.33 the general fund for a grant to the Family
205.34 Enhancement Center for staffing and
205.35 administrative support to provide children

206.1 access to expert mental health services
206.2 regardless of a child's insurance status or
206.3 income. This is a onetime appropriation and
206.4 is available until June 30, 2021.

206.5 **(i) Transitional Housing Program.**

206.6 Notwithstanding Minnesota Statutes, section
206.7 16B.97, \$50,000 in fiscal year 2020 is from
206.8 the general fund for a transitional housing and
206.9 support program located in Rice County that
206.10 serves women and children in crisis to enhance
206.11 current services and supports and to determine
206.12 if the program's model can be expanded
206.13 statewide. The commissioner of human
206.14 services shall report by February 1, 2020, to
206.15 the chairs and ranking minority members of
206.16 the legislative committees with jurisdiction
206.17 over transitional housing programs on the
206.18 outcomes of the program and provide
206.19 recommendations on expanding the program's
206.20 model statewide. This is a onetime
206.21 appropriation.

206.22 **(j) Fraud Prevention Investigations.**

206.23 \$425,000 in fiscal year 2020 and \$425,000 in
206.24 fiscal year 2021 are from the general fund for
206.25 the fraud prevention investigation project
206.26 under Minnesota Statutes, section 256.983.

206.27 **(k) Adaptive Fitness Access Grants.**

206.28 \$125,000 in fiscal year 2020 and \$125,000 in
206.29 fiscal year 2021 are from the general fund for
206.30 the grant program under Minnesota Statutes,
206.31 section 256.488.

206.32 **(l) Day Training and Habilitation Disability**

206.33 **Waiver Rate System Transition Grants.**

206.34 \$200,000 in fiscal year 2020 and \$200,000 in
206.35 fiscal year 2021 are from the general fund for

207.1 day training and habilitation disability waiver
 207.2 rate system transition grants under article ...,
 207.3 section

207.4 (m) **Family Support Grants.** The general
 207.5 fund base for family support grants under
 207.6 Minnesota Statutes, section 252.32, is
 207.7 \$10,278,000 in fiscal year 2022 and
 207.8 \$8,278,000 in fiscal year 2023. The
 207.9 commissioner may use up to \$2,000,000 of
 207.10 the 2022 fiscal year base funding to reimburse
 207.11 counties that issue family support grants in an
 207.12 amount that exceeds the county's allocation in
 207.13 fiscal year 2021. This paragraph expires June
 207.14 20, 2023.

207.15	Sec. 3. <u>COUNCIL ON DISABILITY</u>	\$	<u>156,000</u>	\$	<u>146,000</u>
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207.16	Sec. 4. <u>OMBUDSMAN FOR MENTAL</u>				
207.17	<u>HEALTH AND DEVELOPMENTAL</u>				
207.18	<u>DISABILITIES</u>	\$	<u>250,000</u>	\$	<u>-0-</u>

207.19 **Department of Psychiatry Monitoring.**
 207.20 \$100,000 in fiscal year 2020 and \$100,000 in
 207.21 fiscal year 2021 are for monitoring the
 207.22 Department of Psychiatry at the University of
 207.23 Minnesota.

207.24 Sec. 5. Laws 2017, First Special Session chapter 6, article 18, section 7, is amended to
 207.25 read:

207.26	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>				
207.27	<u>HEALTH AND DEVELOPMENTAL</u>				<u>2,427,000</u>
207.28	<u>DISABILITIES</u>	\$	<u>2,407,000</u>	\$	<u>2,177,000</u>

207.29 **Department of Psychiatry Monitoring.**
 207.30 \$100,000 in fiscal year 2018 and \$100,000 in
 207.31 fiscal year 2019 are for monitoring the
 207.32 Department of Psychiatry at the University of
 207.33 Minnesota.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

119B.011 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Applicant.** "Child care fund applicants" means all parents, stepparents, legal guardians, or eligible relative caregivers who are members of the family and reside in the household that applies for child care assistance under the child care fund.

Subd. 3. **Application.** "Application" means the submission to a county agency, by or on behalf of a family, of a completed, signed, and dated:

- (1) child care assistance universal application form; or
- (2) child care addendum form in combination with a combined application form for MFIP, DWP, or food support.

Subd. 4. **Child.** "Child" means a person 12 years old or younger, or a person age 13 or 14 who is disabled, as defined in section 125A.02.

Subd. 5. **Child care.** "Child care" means the care of a child by someone other than a parent, stepparent, legal guardian, eligible relative caregiver, or the spouses of any of the foregoing in or outside the child's own home for gain or otherwise, on a regular basis, for any part of a 24-hour day.

Subd. 6. **Child care fund.** "Child care fund" means a program under this chapter providing:

- (1) financial assistance for child care to parents engaged in employment, job search, or education and training leading to employment, or an at-home infant child care subsidy; and
- (2) grants to develop, expand, and improve the access and availability of child care services statewide.

Subd. 7. **Child care services.** "Child care services" means the provision of child care as defined in subdivision 5.

Subd. 8. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 9. **County board.** "County board" means the board of county commissioners in each county.

Subd. 10. **Department.** "Department" means the Department of Human Services.

Subd. 10a. **Diversionsary work program.** "Diversionsary work program" means the program established under section 256J.95.

Subd. 11. **Education program.** "Education program" means remedial or basic education or English as a second language instruction, a program leading to a commissioner of education-selected high school equivalency certification or high school diploma, postsecondary programs excluding postbaccalaureate programs, and other education and training needs as documented in an employment plan, as defined in subdivision 12. The employment plan must outline education and training needs of a recipient, meet state requirements for employment plans, meet the requirements of this chapter, and Minnesota Rules, parts 3400.0010 to 3400.0230, and meet the requirements of programs that provide federal reimbursement for child care services.

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Subd. 12. **Employment plan.** "Employment plan" means employment of recipients financially eligible for child care assistance, or other work activities defined under section 256J.49, approved in an employability development, job search support plan, or employment plan that is developed by the county agency, if it is acting as an employment and training service provider, or by an employment and training service provider certified by the commissioner of employment and economic development or an individual designated by the county to provide employment and training services. The plans and designation of a service provider must meet the requirements of this chapter and chapter 256J or 256K, Minnesota Rules, parts 3400.0010 to 3400.0230, and other programs that provide federal reimbursement for child care services.

Subd. 13. **Family.** "Family" means parents, stepparents, guardians and their spouses, or other eligible relative caregivers and their spouses, and their blood related dependent children and adoptive siblings under the age of 18 years living in the same home including children temporarily absent from the household in settings such as schools, foster care, and residential treatment facilities or parents, stepparents, guardians and their spouses, or other relative caregivers and their spouses temporarily absent from the household in settings such as schools, military service, or rehabilitation programs. An adult family member who is not in an authorized activity under this chapter may be temporarily absent for up to 60 days. When a minor parent or parents and his, her, or their child or children are living with other relatives, and the minor parent or parents apply for a child care subsidy, "family" means only the minor parent or parents and their child or children. An adult age 18 or older who meets this definition of family and is a full-time high school or postsecondary student may be considered a dependent member of the family unit if 50 percent or more of the adult's support is provided by the parents, stepparents, guardians, and their spouses or eligible relative caregivers and their spouses residing in the same household.

Subd. 13a. **Family stabilization services.** "Family stabilization services" means the services under section 256J.575.

Subd. 14. **Human services board.** "Human services board" means a board established under section 402.02, Laws 1974, chapter 293, or Laws 1976, chapter 340.

Subd. 15. **Income.** "Income" means earned income as defined under section 256P.01, subdivision 3, unearned income as defined under section 256P.01, subdivision 8, and public assistance cash benefits, including the Minnesota family investment program, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, and child support and maintenance distributed to the family under section 256.741, subdivision 2a. The following are deducted from income: funds used to pay for health insurance premiums for family members, and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources not included in this subdivision and section 256P.06, subdivision 3, are not counted.

Subd. 16. **Legal nonlicensed child care provider.** "Legal nonlicensed child care provider" means: (1) a child care provider who is excluded from licensing requirements under section 245A.03, subdivision 2; or (2) a child care provider authorized to provide care in a child's home under section 119B.09, subdivision 13, provided the provider only cares for related children, children from a single, unrelated family, or both related children and children from a single, unrelated family.

Subd. 17. **MFIP.** "MFIP" means the Minnesota family investment program, the state's TANF program under Public Law 104-193, Title I, and includes the MFIP program under chapter 256J and tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2.

Subd. 18. **Postsecondary educational systems.** "Postsecondary educational systems" means the University of Minnesota Board of Regents and the Board of Trustees of the Minnesota State Colleges and Universities.

Subd. 19. **Provider.** "Provider" means: (1) an individual or child care center or facility, either licensed or unlicensed, providing legal child care services as defined under section 245A.03; or (2) an individual or child care center or facility holding a valid child care license issued by another state or a tribe and providing child care services in the licensing state or in the area under the licensing tribe's jurisdiction. A legally unlicensed family child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

Subd. 19a. **Registration.** "Registration" means the process used by a county to determine whether the provider selected by a family applying for or receiving child care assistance to care for that family's children meets the requirements necessary for payment of child care assistance for care provided by that provider.

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Subd. 19b. **Student parent.** "Student parent" means a person who is:

- (1) under 21 years of age and has a child;
- (2) pursuing a high school diploma or commissioner of education-selected high school equivalency certification;
- (3) residing within a county that has a basic sliding fee waiting list under section 119B.03, subdivision 4; and
- (4) not an MFIP participant.

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least three of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

Subd. 20a. **Transition year extension families.** "Transition year extension families" means families who have completed their transition year of child care assistance under this subdivision and who are eligible for, but on a waiting list for, services under section 119B.03. For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2), families participating in extended transition year shall not be considered transition year families. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year extension child care may be used to support employment, approved education or training programs, or a job search that meets the requirements of section 119B.10 for the length of time necessary for families to be moved from the basic sliding fee waiting list into the basic sliding fee program.

Subd. 21. **Recoupment of overpayments.** "Recoupment of overpayments" means the reduction of child care assistance payments to an eligible family or a child care provider in order to correct an overpayment of child care assistance.

Subd. 22. **Service period.** "Service period" means the biweekly period used by the child care assistance program for billing and payment purposes.

119B.02 DUTIES OF COMMISSIONER.

Subdivision 1. **Child care services.** The commissioner shall develop standards for county and human services boards to provide child care services to enable eligible families to participate in employment, training, or education programs. Within the limits of available appropriations, the commissioner shall distribute money to counties to reduce the costs of child care for eligible families. The commissioner shall adopt rules to govern the program in accordance with this section. The rules must establish a sliding schedule of fees for parents receiving child care services. The rules shall provide that funds received as a lump-sum payment of child support arrearages shall not be counted as income to a family in the month received but shall be prorated over the 12 months following receipt and added to the family income during those months. The commissioner shall maximize the use of federal money under title I and title IV of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and other programs that provide federal or state reimbursement for child care services for low-income families who are in education, training, job search, or other activities allowed under those programs. Money appropriated under this section must be coordinated with the programs that provide federal reimbursement for child care services to accomplish this purpose. Federal reimbursement obtained must be allocated to the county that spent money for child care that is federally reimbursable under programs that provide federal reimbursement for child care services. The counties shall use the federal money to expand child care services. The commissioner may adopt rules under chapter 14 to implement and coordinate federal program requirements.

Subd. 2. **Contractual agreements with tribes.** The commissioner may enter into contractual agreements with a federally recognized Indian tribe with a reservation in Minnesota to carry out the responsibilities of county human service agencies to the extent necessary for the tribe to operate child care assistance programs under sections 119B.03 and 119B.05. An agreement may allow the state to make payments for child care assistance services provided under section 119B.05. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of

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county and tribal child care services. Funding to support services under section 119B.03 may be transferred to the federally recognized Indian tribe with a reservation in Minnesota from allocations available to counties in which reservation boundaries lie. When funding is transferred under section 119B.03, the amount shall be commensurate to estimates of the proportion of reservation residents with characteristics identified in section 119B.03, subdivision 6, to the total population of county residents with those same characteristics.

Subd. 3. **Supervision of counties.** The commissioner shall supervise child care programs administered by the counties through standard-setting, technical assistance to the counties, approval of county child care fund plans, and distribution of public money for services. The commissioner shall provide training and other support services to assist counties in planning for and implementing child care assistance programs. The commissioner shall adopt rules under chapter 14 that establish minimum administrative standards for the provision of child care services by county boards of commissioners.

Subd. 4. **Universal application form.** The commissioner must develop and make available to all counties a universal application form for child care assistance under this chapter. The commissioner may develop and make available to all counties a child care addendum form to be used to supplement the combined application form for MFIP, DWP, or Food Support or to supplement other statewide application forms for public assistance programs for families applying for one of these programs in addition to child care assistance. The application must provide notice of eligibility requirements for assistance and penalties for wrongfully obtaining assistance.

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983.

Subd. 6. **Data.** Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance shall be treated as licensing data as provided in section 13.46, subdivision 4.

Subd. 7. **Child care market rate survey.** Biennially, the commissioner shall survey prices charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in county price clusters.

119B.025 DUTIES OF COUNTIES.

Subdivision 1. **Applications.** (a) The county shall verify the following at all initial child care applications using the universal application:

- (1) identity of adults;
- (2) presence of the minor child in the home, if questionable;
- (3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;
- (4) age;
- (5) immigration status, if related to eligibility;
- (6) Social Security number, if given;
- (7) counted income;
- (8) spousal support and child support payments made to persons outside the household;
- (9) residence; and
- (10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

Subd. 2. **Social Security numbers.** The county must request Social Security numbers from all applicants for child care assistance under this chapter. A county may not deny child care assistance solely on the basis of failure of an applicant to report a Social Security number.

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

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(b) The county shall use the redetermination form developed by the commissioner. The county must verify the factors listed in subdivision 1, paragraph (a), as part of the redetermination.

(c) An applicant's eligibility must be redetermined no more frequently than every 12 months. The following criteria apply:

(1) a family meets the eligibility redetermination requirements if a complete redetermination form and all required verifications are received within 30 days after the date the form was due;

(2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday, the 30-day time period is extended to include the next day that is not a Saturday, Sunday, or holiday. Assistance shall be payable retroactively from the redetermination due date;

(3) for a family where at least one parent is younger than 21 years of age, does not have a high school degree or commissioner of education-selected high school equivalency certification, and is a student in a school district or another similar program that provides or arranges for child care, parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility may be deferred beyond 12 months, to the end of the student's school year; and

(4) a family and the family's providers must be notified that the family's redetermination is due at least 45 days before the end of the family's 12-month eligibility period.

Subd. 4. **Changes in eligibility.** (a) The county shall process a change in eligibility factors according to paragraphs (b) to (g).

(b) A family is subject to the reporting requirements in section 256P.07.

(c) If a family reports a change or a change is known to the agency before the family's regularly scheduled redetermination, the county must act on the change. The commissioner shall establish standards for verifying a change.

(d) A change in income occurs on the day the participant received the first payment reflecting the change in income.

(e) During a family's 12-month eligibility period, if the family's income increases and remains at or below 85 percent of the state median income, adjusted for family size, there is no change to the family's eligibility. The county shall not request verification of the change. The co-payment fee shall not increase during the remaining portion of the family's 12-month eligibility period.

(f) During a family's 12-month eligibility period, if the family's income increases and exceeds 85 percent of the state median income, adjusted for family size, the family is not eligible for child care assistance. The family must be given 15 calendar days to provide verification of the change. If the required verification is not returned or confirms ineligibility, the family's eligibility ends following a subsequent 15-day adverse action notice.

(g) Notwithstanding Minnesota Rules, parts 3400.0040, subpart 3, and 3400.0170, subpart 1, if an applicant or participant reports that employment ended, the agency may accept a signed statement from the applicant or participant as verification that employment ended.

119B.03 BASIC SLIDING FEE PROGRAM.

Subdivision 1. **Notice of allocation.** By October 1 of each year, the commissioner shall notify all counties of their final child care fund program allocation.

Subd. 2. **Waiting list.** Each county that receives funds under this section must keep a written record and report to the commissioner the number of eligible families who have applied for a child care subsidy or have requested child care assistance. Counties shall perform a preliminary determination of eligibility when a family requests child care assistance. At a minimum, a county must make a preliminary determination of eligibility based on family size, income, and authorized activity. A family seeking child care assistance must provide the required information to the county. A family that appears to be eligible must be put on a waiting list if funds are not immediately available. The waiting list must identify students in need of child care. Counties must review and update their waiting list at least every six months.

Subd. 3. **Eligible participants.** Families that meet the eligibility requirements under sections 119B.09 and 119B.10, except MFIP participants, diversionary work program, and transition year families are eligible for child care assistance under the basic sliding fee program. Families enrolled in the basic sliding fee program shall be continued until they are no longer eligible. Child care assistance provided through the child care fund is considered assistance to the parent.

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Subd. 4. **Funding priority.** (a) First priority for child care assistance under the basic sliding fee program must be given to eligible non-MFIP families who do not have a high school diploma or commissioner of education-selected high school equivalency certification or who need remedial and basic skill courses in order to pursue employment or to pursue education leading to employment and who need child care assistance to participate in the education program. This includes student parents as defined under section 119B.011, subdivision 19b. Within this priority, the following subpriorities must be used:

- (1) child care needs of minor parents;
- (2) child care needs of parents under 21 years of age; and
- (3) child care needs of other parents within the priority group described in this paragraph.

(b) Second priority must be given to parents who have completed their MFIP or DWP transition year, or parents who are no longer receiving or eligible for diversionary work program supports.

(c) Third priority must be given to families who are eligible for portable basic sliding fee assistance through the portability pool under subdivision 9.

(d) Fourth priority must be given to families in which at least one parent is a veteran as defined under section 197.447.

(e) Families under paragraph (b) must be added to the basic sliding fee waiting list on the date they begin the transition year under section 119B.011, subdivision 20, and must be moved into the basic sliding fee program as soon as possible after they complete their transition year.

Subd. 5. **Review of use of funds; reallocation.** (a) After each quarter, the commissioner shall review the use of basic sliding fee program allocations by county. The commissioner may reallocate unexpended or unencumbered money among those counties who have expended their full allocation or may allow a county to expend up to ten percent of its allocation in the subsequent allocation period.

(b) Any unexpended state and federal appropriations from the first year of the biennium may be carried forward to the second year of the biennium.

Subd. 6. **Allocation formula.** The basic sliding fee state and federal funds shall be allocated on a calendar year basis. Funds shall be allocated first in amounts equal to each county's guaranteed floor according to subdivision 8, with any remaining available funds allocated according to the following formula:

(a) One-fourth of the funds shall be allocated in proportion to each county's total expenditures for the basic sliding fee child care program reported during the most recent fiscal year completed at the time of the notice of allocation.

(b) Up to one-fourth of the funds shall be allocated in proportion to the number of families participating in the transition year child care program as reported during and averaged over the most recent six months completed at the time of the notice of allocation. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (f).

(c) Up to one-fourth of the funds shall be allocated in proportion to the average of each county's most recent six months of reported first, second, and third priority waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (f).

(d) Up to one-fourth of the funds shall be allocated in proportion to the average of each county's most recent six months of reported waiting list as defined in subdivision 2 and the reinstatement list of those families whose assistance was terminated with the approval of the commissioner under Minnesota Rules, part 3400.0183, subpart 1. Funds in excess of the amount necessary to serve all families in this category shall be allocated according to paragraph (f).

(e) The amount necessary to serve all families in paragraphs (b), (c), and (d) shall be calculated based on the basic sliding fee average cost of care per family in the county with the highest cost in the most recently completed calendar year.

(f) Funds in excess of the amount necessary to serve all families in paragraphs (b), (c), and (d) shall be allocated in proportion to each county's total expenditures for the basic sliding fee child

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care program reported during the most recent fiscal year completed at the time of the notice of allocation.

Subd. 6a. **Allocation due to increased funding.** When funding increases are implemented within a calendar year, every county must receive an allocation at least equal to its original allocation for the same time period. The remainder of the allocation must be recalculated to reflect the funding increase, according to formulas identified in subdivision 6.

Subd. 6b. **Allocation due to decreased funding.** When funding decreases are implemented within a calendar year, county allocations must be reduced in an amount proportionate to the reduction in the total allocation for the same time period. This applies when a funding decrease necessitates the revision of an existing calendar year allocation.

Subd. 8. **Guaranteed floor.** (a) Beginning January 1, 1996, each county's guaranteed floor shall equal 90 percent of the allocation received in the preceding calendar year. For the period January 1, 1999, to December 31, 1999, each county's guaranteed floor must be equal to its original calendar year 1998 allocation or its actual earnings for calendar year 1998, whichever is less.

(b) When the amount of funds available for allocation is less than the amount available in the previous year, each county's previous year allocation shall be reduced in proportion to the reduction in the statewide funding, for the purpose of establishing the guaranteed floor.

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) To be eligible for portable basic sliding fee assistance, a family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue basic sliding fee assistance for the lesser of six months or until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

Subd. 10. **Application; entry points.** Two or more methods of applying for the basic sliding fee program must be available to applicants in each county. To meet the requirements of this subdivision, a county may provide alternative methods of applying for assistance, including, but not limited to, a mail application, or application sites that are located outside of government offices.

119B.035 AT-HOME INFANT CHILD CARE PROGRAM.

Subdivision 1. **Establishment.** A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, except as provided in subdivision 4, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, and up to available appropriations, the commissioner shall provide assistance under the at-home infant child care program and for administrative costs associated with the program. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Subd. 2. **Eligible families.** A family with an infant under the age of one year is eligible for assistance if:

(1) the family is not receiving MFIP, other cash assistance, or other child care assistance;

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(2) the family has not previously received a lifelong total of 12 months of assistance under this section; and

(3) the family is participating in the basic sliding fee program or provides verification of participating in an authorized activity at the time of application and meets the program requirements.

Subd. 3. **Eligible parent.** A family is eligible for assistance under this section if one parent cares for the family's infant child. The eligible parent must:

(1) be over the age of 18;

(2) care for the infant full time in the infant's home; and

(3) care for any other children in the family who are eligible for child care assistance under this chapter.

For purposes of this section, "parent" means birth parent, adoptive parent, or stepparent.

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to 68 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

(b) A participating family must report income and other family changes as specified in sections 256P.06 and 256P.07, and the county's plan under section 119B.08, subdivision 3.

(c) Persons who are admitted to the at-home infant child care program retain their position in any basic sliding fee program. Persons leaving the at-home infant child care program reenter the basic sliding fee program at the position they would have occupied.

(d) Assistance under this section does not establish an employer-employee relationship between any member of the assisted family and the county or state.

Subd. 5. **Implementation.** The commissioner shall implement the at-home infant child care program under this section through counties that administer the basic sliding fee program under section 119B.03. The commissioner must develop and distribute consumer information on the at-home infant child care program to assist parents of infants or expectant parents in making informed child care decisions.

119B.04 FEDERAL CHILD CARE AND DEVELOPMENT FUND.

Subdivision 1. **Commissioner to administer program.** The commissioner is authorized and directed to receive, administer, and expend funds available under the child care and development fund under Public Law 104-193, Title VI.

Subd. 2. **Rulemaking authority.** The commissioner may adopt rules under chapter 14 to administer the child care and development fund.

119B.05 MFIP CHILD CARE ASSISTANCE PROGRAM.

Subdivision 1. **Eligible participants.** Families eligible for child care assistance under the MFIP child care program are:

(1) MFIP participants who are employed or in job search and meet the requirements of section 119B.10;

(2) persons who are members of transition year families under section 119B.011, subdivision 20, and meet the requirements of section 119B.10;

(3) families who are participating in employment orientation or job search, or other employment or training activities that are included in an approved employability development plan under section 256J.95;

(4) MFIP families who are participating in work job search, job support, employment, or training activities as required in their employment plan, or in appeals, hearings, assessments, or orientations according to chapter 256J;

(5) MFIP families who are participating in social services activities under chapter 256J as required in their employment plan approved according to chapter 256J;

(6) families who are participating in services or activities that are included in an approved family stabilization plan under section 256J.575;

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(7) families who are participating in programs as required in tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2;

(8) families who are participating in the transition year extension under section 119B.011, subdivision 20a;

(9) student parents as defined under section 119B.011, subdivision 19b; and

(10) student parents who turn 21 years of age and who continue to meet the other requirements under section 119B.011, subdivision 19b. A student parent continues to be eligible until the student parent is approved for basic sliding fee child care assistance or until the student parent's redetermination, whichever comes first. At the student parent's redetermination, if the student parent was not approved for basic sliding fee child care assistance, a student parent's eligibility ends following a 15-day adverse action notice.

Subd. 4. Contracts; other uses allowed. Counties may contract for administration of the program or may arrange for or contract for child care funds to be used by other appropriate programs, in accordance with this section and as permitted by federal law and regulations.

Subd. 5. Federal reimbursement. Counties shall maximize their federal reimbursement under federal reimbursement programs for money spent for persons eligible under this chapter. The commissioner shall allocate any federal earnings to the county to be used to expand child care services under this chapter.

119B.06 FEDERAL CHILD CARE AND DEVELOPMENT BLOCK GRANT.

Subdivision 1. Commissioner to administer block grant. The commissioner is authorized and directed to receive, administer, and expend child care funds available under the child care and development block grant authorized under the Child Care and Development Block Grant Act of 2014, Public Law 113-186.

Subd. 2. Rulemaking authority. The commissioner may adopt rules under chapter 14 to administer the child care development block grant program.

Subd. 3. Child care development fund plan development; review. In an effort to improve state legislative involvement in the development of the Minnesota child care and development fund plan, the commissioner must present a draft copy of the plan to the legislative finance committees that oversee child care assistance funding no less than 30 days prior to the required deadline for submission of the plan to the federal government. The legislature must submit any adjustments to the plan to the commissioner for consideration within ten business days of receiving the draft plan. The commissioner must present a copy of the final plan to the chairs of the legislative finance committees that oversee child care assistance funding no less than four days prior to the deadline for submission of the plan to the federal government.

119B.08 REPORTING AND PAYMENTS.

Subdivision 1. Reports. The commissioner shall specify requirements for reports under the authority provided in section 256.01, subdivision 2, paragraph (p).

Subd. 2. Monthly payments. The commissioner shall make monthly payments on a reimbursement basis for expenditures reported outside of the electronic system used to administer child care assistance. Payments may be withheld if monthly reports are incomplete or untimely.

Subd. 3. Child care fund plan. The county and designated administering agency shall submit a biennial child care fund plan to the commissioner. The commissioner shall establish the dates by which the county must submit the plans. The plan shall include:

(1) a description of strategies to coordinate and maximize public and private community resources, including school districts, health care facilities, government agencies, neighborhood organizations, and other resources knowledgeable in early childhood development, in particular to coordinate child care assistance with existing community-based programs and service providers including child care resource and referral programs, early childhood family education, school readiness, Head Start, local interagency early intervention committees, special education services, early childhood screening, and other early childhood care and education services and programs to the extent possible, to foster collaboration among agencies and other community-based programs that provide flexible, family-focused services to families with young children and to facilitate transition into kindergarten. The county must describe a method by which to share information, responsibility, and accountability among service and program providers;

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(2) a description of procedures and methods to be used to make copies of the proposed state plan reasonably available to the public, including members of the public particularly interested in child care policies such as parents, child care providers, culturally specific service organizations, child care resource and referral programs, interagency early intervention committees, potential collaborative partners and agencies involved in the provision of care and education to young children, and allowing sufficient time for public review and comment; and

(3) information as requested by the department to ensure compliance with the child care fund statutes and rules promulgated by the commissioner.

The commissioner shall notify counties within 90 days of the date the plan is submitted whether the plan is approved or the corrections or information needed to approve the plan. The commissioner shall withhold a county's allocation until it has an approved plan. Plans not approved by the end of the second quarter after the plan is due may result in a 25 percent reduction in allocation. Plans not approved by the end of the third quarter after the plan is due may result in a 100 percent reduction in the allocation to the county. Counties are to maintain services despite any reduction in their allocation due to plans not being approved.

119B.09 FINANCIAL ELIGIBILITY.

Subdivision 1. **General eligibility requirements.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 67 percent of the state median income, adjusted for family size, at application and redetermination, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J; or

(2) have household income less than or equal to 47 percent of the state median income, adjusted for family size, at application and less than or equal to 67 percent of the state median income, adjusted for family size, at redetermination.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family at application and redetermination as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

(d) All applicants for child care assistance and families currently receiving child care assistance must pay the co-payment fee under section 119B.12, subdivision 2, as a condition of eligibility. The co-payment fee may include additional recoupment fees due to a child care assistance program overpayment.

Subd. 3. **Priorities; allocations.** If a county projects that its child care allocation is insufficient to meet the needs of all eligible families, it may prioritize among the families that remain to be served after the county has complied with the priority requirements of section 119B.03. Counties that have established a priority for families who are not MFIP participants beyond those established under section 119B.03 must submit the policy in the annual child care fund plan.

Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant family is the current monthly income of the family multiplied by 12 or the income for the 12-month period immediately preceding the date of application, or income calculated by the method which provides the most accurate assessment of income available to the family.

(b) Self-employment income must be calculated based on gross receipts less operating expenses.

(c) Income changes are processed under section 119B.025, subdivision 4. Included lump sums counted as income under section 256P.06, subdivision 3, must be annualized over 12 months. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

Subd. 4a. **Temporary ineligibility of military personnel.** Counties must reserve a family's position under the child care assistance fund if a family has been receiving child care assistance but is temporarily ineligible for assistance due to increased income from active military service. Activated military personnel may be temporarily ineligible until deactivation. A county must reserve a military family's position on the basic sliding fee waiting list under the child care assistance fund

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if a family is approved to receive child care assistance and reaches the top of the waiting list but is temporarily ineligible for assistance.

Subd. 5. **Provider choice.** Parents may choose child care providers as defined under section 119B.011, subdivision 19, that best meet the needs of their family. Counties shall make resources available to parents in choosing quality child care services. Counties may require a parent to sign a release stating their knowledge and responsibilities in choosing a legal provider described under section 119B.011, subdivision 19. When a county knows that a particular provider is unsafe, or that the circumstances of the child care arrangement chosen by the parent are unsafe, the county may deny a child care subsidy. A county may not restrict access to a general category of provider allowed under section 119B.011, subdivision 19.

Subd. 6. **Maximum child care assistance.** The maximum amount of child care assistance a local agency may pay for in a two-week period is 120 hours per child.

Subd. 7. **Date of eligibility for assistance.** (a) The date of eligibility for child care assistance under this chapter is the later of the date the application was received by the county; the beginning date of employment, education, or training; the date the infant is born for applicants to the at-home infant care program; or the date a determination has been made that the applicant is a participant in employment and training services under Minnesota Rules, part 3400.0080, or chapter 256J.

(b) Payment ceases for a family under the at-home infant child care program when a family has used a total of 12 months of assistance as specified under section 119B.035. Payment of child care assistance for employed persons on MFIP is effective the date of employment or the date of MFIP eligibility, whichever is later. Payment of child care assistance for MFIP or DWP participants in employment and training services is effective the date of commencement of the services or the date of MFIP or DWP eligibility, whichever is later. Payment of child care assistance for transition year child care must be made retroactive to the date of eligibility for transition year child care.

(c) Notwithstanding paragraph (b), payment of child care assistance for participants eligible under section 119B.05 may only be made retroactive for a maximum of six months from the date of application for child care assistance.

Subd. 8. **No employee-employer relationships.** Receipt of federal, state, or local funds by a child care provider either directly or through a parent who is a child care assistance recipient does not establish an employee-employer relationship between the child care provider and the county or state.

Subd. 9. **Licensed and legal nonlicensed family child care providers; assistance.** This subdivision applies to any provider providing care in a setting other than a child care center. Licensed and legal nonlicensed family child care providers and their employees are not eligible to receive child care assistance subsidies under this chapter for their own children or children in their family during the hours they are providing child care or being paid to provide child care. Child care providers and their employees are eligible to receive child care assistance subsidies for their children when they are engaged in other activities that meet the requirements of this chapter and for which child care assistance can be paid. The hours for which the provider or their employee receives a child care subsidy for their own children must not overlap with the hours the provider provides child care services.

Subd. 9a. **Child care centers; assistance.** (a) A child care center may receive authorizations for 25 or fewer children who are dependents of the center's employees. If a child care center is authorized for more than 25 children who are dependents of center employees, the county cannot authorize additional dependents of an employee until the number of children falls below 25.

(b) Funds paid to providers during the period of time when a center is authorized for more than 25 children who are dependents of center employees must not be treated as overpayments under section 119B.11, subdivision 2a, due to noncompliance with this subdivision.

(c) Nothing in this subdivision precludes the commissioner from conducting fraud investigations relating to child care assistance, imposing sanctions, and obtaining monetary recovery as otherwise provided by law.

Subd. 10. **Payment of funds.** All federal, state, and local child care funds must be paid directly to the parent when a provider cares for children in the children's own home. In all other cases, all federal, state, and local child care funds must be paid directly to the child care provider, either licensed or legal nonlicensed, on behalf of the eligible family. Funds distributed under this chapter must not be used for child care services that are provided for a child by a child care provider who resides in the same household or occupies the same residence as the child.

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Subd. 11. **Payment of other child care expenses.** Payment by a source other than the family, of part or all of a family's child care expenses not payable under this chapter, does not affect the family's eligibility for child care assistance, and the amount paid is excluded from the family's income, if the funds are paid directly to the family's child care provider on behalf of the family. Child care providers who accept third-party payments must maintain family-specific documentation of payment source, amount, type of expenses, and time period covered by the payment.

Subd. 12. **Sliding fee.** Child care services to families must be made available on a sliding fee basis. The commissioner shall convert eligibility requirements in this section and parent fee schedules in section 119B.12 to state median income, based on a family size of three, adjusted for family size, by July 1, 2008. The commissioner shall report to the 2008 legislature with the necessary statutory changes to codify this conversion to state median income.

Subd. 13. **Child care in the child's home.** (a) Child care assistance must only be authorized in the child's home if:

(1) the child's parents have authorized activities outside of the home; or

(2) one parent in a two-parent family is in an authorized activity outside of the home and one parent is unable to care for the child and meets the requirements in Minnesota Rules, part 3400.0040, subpart 5.

(b) In order for child care assistance to be authorized under paragraph (a), clause (1) or (2), one or more of the following circumstances must be met:

(1) the authorized activity occurs during times when out-of-home care is not available or when out-of-home care would result in disruption of the child's nighttime sleep schedule. If child care is needed during any period when out-of-home care is not available, in-home care can be approved for the entire time care is needed;

(2) the family lives in an area where out-of-home care is not available; or

(3) a child has a verified illness or disability that would place the child or other children in an out-of-home facility at risk or creates a hardship for the child and the family to take the child out of the home to a child care home or center.

119B.095 CHILD CARE AUTHORIZATIONS.

Subdivision 1. **General authorization requirements.** (a) When authorizing the amount of child care, the county agency must consider the amount of time the parent reports on the application or redetermination form that the child attends preschool, a Head Start program, or school while the parent is participating in an authorized activity.

(b) Care must be authorized and scheduled with a provider based on the applicant's or participant's verified activity schedule when:

(1) the family requests care from more than one provider per child;

(2) the family requests care from a legal nonlicensed provider; or

(3) an applicant or participant is employed by any child care center that is licensed by the Department of Human Services or has been identified as a high-risk Medicaid-enrolled provider.

(c) If the family remains eligible at redetermination, a new authorization with fewer hours, the same hours, or increased hours may be determined.

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

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(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

- (1) the child's school schedule;
- (2) the custody schedule; or
- (3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

119B.097 AUTHORIZATION WITH A SECONDARY PROVIDER.

(a) If a child uses any combination of the following providers paid by child care assistance, a parent must choose one primary provider and one secondary provider per child that can be paid by child care assistance:

- (1) an individual or child care center licensed under chapter 245A;
- (2) an individual or child care center or facility holding a valid child care license issued by another state or tribe; or
- (3) a child care center exempt from licensing under section 245A.03.

(b) The amount of child care authorized with the secondary provider cannot exceed 20 hours per two-week service period, per child, and the amount of care paid to a child's secondary provider is limited under section 119B.13, subdivision 1. The total amount of child care authorized with both the primary and secondary provider cannot exceed the amount of child care allowed based on the parents' eligible activity schedule, the child's school schedule, and any other factors relevant to the family's child care needs.

119B.10 EMPLOYMENT, EDUCATION, OR TRAINING ELIGIBILITY.

Subdivision 1. **Assistance for persons seeking and retaining employment.** (a) Persons who are seeking employment and who are eligible for assistance under this section are eligible to receive up to 240 hours of child care assistance per calendar year.

(b) At application and redetermination, employed persons who work at least an average of 20 hours and full-time students who work at least an average of ten hours a week and receive at least a minimum wage for all hours worked are eligible for child care assistance for employment. For purposes of this section, work-study programs must be counted as employment. An employed person with an MFIP or DWP employment plan shall receive child care assistance as specified in the person's employment plan. Child care assistance during employment must be authorized as provided in paragraphs (c) and (d).

(c) When the person works for an hourly wage and the hourly wage is equal to or greater than the applicable minimum wage, child care assistance shall be provided for the hours of employment, break, and mealtime during the employment and travel time up to two hours per day.

(d) When the person does not work for an hourly wage, child care assistance must be provided for the lesser of:

- (1) the amount of child care determined by dividing gross earned income by the applicable minimum wage, up to one hour every eight hours for meals and break time, plus up to two hours per day for travel time; or
- (2) the amount of child care equal to the actual amount of child care used during employment, including break and mealtime during employment, and travel time up to two hours per day.

Subd. 2. **Financial eligibility required.** Persons participating in employment programs, training programs, or education programs are eligible for continued assistance from the child care fund, if they are financially eligible under the sliding fee scale set by the commissioner in section 119B.12.

Subd. 3. **Assistance for persons attending an approved education or training program.** (a) Money for an eligible person according to sections 119B.03, subdivision 3, and 119B.05, subdivision 1, shall be used to reduce child care costs for a student. The county shall not limit the duration of child care subsidies for a person in an employment or educational program unless the person is ineligible for child care funds. Any other limitation must be based on county policies included in the approved child care fund plan.

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(b) To be eligible, the student must be in good standing and be making satisfactory progress toward the degree. The maximum length of time a student is eligible for child care assistance under the child care fund for education and training is no more than the time necessary to complete the credit requirements for an associate's or baccalaureate degree as determined by the educational institution. Time limitations for child care assistance do not apply to basic or remedial educational programs needed for postsecondary education or employment. Basic or remedial educational programs include high school, commissioner of education-selected high school equivalency, and English as a second language programs. A program exempt from this time limit must not run concurrently with a postsecondary program.

(c) If a student meets the conditions of paragraphs (a) and (b), child care assistance must be authorized for all hours of class time and credit hours, including independent study and internships, and up to two hours of travel time per day. A postsecondary student shall receive four hours of child care assistance per credit hour for study time and academic appointments per service period.

(d) For an MFIP or DWP participant, child care assistance must be authorized according to the person's approved employment plan. If an MFIP or DWP participant receiving MFIP or DWP child care assistance under this chapter moves to another county, continues to participate in an authorized educational or training program, and remains eligible for MFIP or DWP child care assistance, the participant must receive continued child care assistance from the county responsible for the person's current employment plan under section 256G.07.

(e) If a person with an approved education program under section 119B.03, subdivision 3, or 119B.05, subdivision 1, begins receiving MFIP or DWP assistance, the person continues to receive child care assistance for the approved education program until the person's education is included in an approved MFIP or DWP employment plan or until redetermination, whichever occurs first.

(f) If a person's MFIP or DWP assistance ends and the approved MFIP or DWP employment plan included education, the person continues to be eligible for child care assistance for education under transition year child care assistance until the person's education is included in an approved education plan or until redetermination.

119B.105 EXTENDED ELIGIBILITY AND AUTHORIZATION.

Subdivision 1. **Three-month extended eligibility period.** (a) A family in a situation under paragraph (b) continues to be eligible for up to three months or until the family's redetermination, whichever occurs first, rather than losing eligibility or having the family's eligibility suspended. During extended eligibility, the amount of child care authorized shall continue at the same number or more hours. The family must continue to meet all other eligibility requirements under this chapter.

(b) The family's three-month extended eligibility period applies when:

(1) a participant's employment or education program ends permanently;

(2) the other parent moves in and does not participate in an authorized activity;

(3) a participant's MFIP assistance ends and the participant is not participating in an authorized activity or the participant's participation in an authorized activity is unknown;

(4) a student parent under section 119B.011, subdivision 19b, stops attending school; or

(5) a participant receiving basic sliding fee child care assistance or transition year child care assistance applied for MFIP assistance and is not participating in an authorized activity or the participant's participation in an authorized activity is unknown.

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan that meets the requirements of section 119B.10, subdivision 3, or have an MFIP or DWP employment plan. If child care assistance continues, the amount of child care authorized shall continue at the same number or more hours until redetermination, unless a condition in section 119B.095, subdivision 2, paragraph (c), applies. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. If child care assistance continues, the amount of child care authorized is based on section 119B.10. A family

subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

119B.11 COUNTY CONTRIBUTION.

Subdivision 1. **County contributions required.** (a) In addition to payments from basic sliding fee child care program participants, each county shall contribute from county tax or other sources a fixed local match equal to its calendar year 1996 required county contribution reduced by the administrative funding loss that would have occurred in state fiscal year 1996 under section 119B.15. The commissioner shall recover funds from the county as necessary to bring county expenditures into compliance with this subdivision. The commissioner may accept county contributions, including contributions above the fixed local match, in order to make state payments.

(b) The commissioner may accept payments from counties to:

(1) fulfill the county contribution as required under subdivision 1;

(2) pay for services authorized under this chapter beyond those paid for with federal or state funds or with the required county contributions; or

(3) pay for child care services in addition to those authorized under this chapter, as authorized under other federal, state, or local statutes or regulations.

(c) The county payments must be deposited in an account in the special revenue fund. Money in this account is appropriated to the commissioner for child care assistance under this chapter and other applicable statutes and regulations and is in addition to other state and federal appropriations.

Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a recipient in excess of the payment due is recoverable by the county agency under paragraphs (b) and (c), even when the overpayment was caused by agency error or circumstances outside the responsibility and control of the family or provider.

(b) An overpayment must be recouped or recovered from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under child care assistance program requirements. If the family remains eligible for child care assistance, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and collected on a service period basis. If the family no longer remains eligible for child care assistance, the county may choose to initiate efforts to recover overpayments from the family for overpayment less than \$50. If the overpayment is greater than or equal to \$50, the county shall seek voluntary repayment of the overpayment from the family. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A family with an outstanding debt under this subdivision is not eligible for child care assistance until: (1) the debt is paid in full; or (2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements.

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than \$50 from the provider. If the overpayment is greater than or equal to \$50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; or

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(2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

Subd. 3. **Federal money; state recovery.** The commissioner shall recover from counties any state or federal money that was spent for persons found to be ineligible, except if the recovery is made by a county agency using any method other than recoupment, the county may keep 25 percent of the recovery. If a federal audit exception is taken based on a percentage of federal earnings, all counties shall pay a share proportional to their respective federal earnings during the period in question.

Subd. 4. **Maintenance of funding effort.** To receive money through this program, each county shall certify, in its annual plan to the commissioner, that the county has not reduced allocations from other federal and state sources, which, in the absence of the child care fund, would have been available for child care assistance. However, the county must continue contributions, as necessary, to maintain on the basic sliding fee program, families who are receiving assistance on July 1, 1995, until the family loses eligibility for the program or until a family voluntarily withdraws from the program. This subdivision does not affect the local match required for this program under other sections of the law.

119B.12 SLIDING FEE SCALE.

Subdivision 1. **Fee schedule.** All changes to parent fees must be implemented on the first Monday of the service period following the effective date of the change.

PARENT FEE SCHEDULE. The parent fee schedule is as follows, except as noted in subdivision 2:

Income Range (as a percent of the state median income, except at the start of the first tier)	Co-payment (as a percentage of adjusted gross income)
0-74.99% of federal poverty guidelines	\$0/biweekly
75.00-99.99% of federal poverty guidelines	\$2/biweekly
100.00% of federal poverty guidelines-27.72%	2.61%
27.73-29.04%	2.61%
29.05-30.36%	2.61%
30.37-31.68%	2.61%
31.69-33.00%	2.91%
33.01-34.32%	2.91%
34.33-35.65%	2.91%
35.66-36.96%	2.91%
36.97-38.29%	3.21%
38.30-39.61%	3.21%
39.62-40.93%	3.21%
40.94-42.25%	3.84%
42.26-43.57%	3.84%
43.58-44.89%	4.46%
44.90-46.21%	4.76%

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46.22-47.53%	5.05%
47.54-48.85%	5.65%
48.86-50.17%	5.95%
50.18-51.49%	6.24%
51.50-52.81%	6.84%
52.82-54.13%	7.58%
54.14-55.45%	8.33%
55.46-56.77%	9.20%
56.78-58.09%	10.07%
58.10-59.41%	10.94%
59.42-60.73%	11.55%
60.74-62.06%	12.16%
62.07-63.38%	12.77%
63.39-64.70%	13.38%
64.71-67.00%	14.00%
Greater than 67.00%	ineligible

A family's biweekly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

Subd. 2. **Parent fee.** A family must be assessed a parent fee for each service period. A family's parent fee must be a fixed percentage of its annual gross income. Parent fees must apply to families eligible for child care assistance under sections 119B.03 and 119B.05. Income must be as defined in section 119B.011, subdivision 15. The fixed percentage is based on the relationship of the family's annual gross income to 100 percent of the annual state median income. Parent fees must begin at 75 percent of the poverty level. The minimum parent fees for families between 75 percent and 100 percent of poverty level must be \$2 per biweekly period. Parent fees must provide for graduated movement to full payment. At initial application, the parent fee is established for the family's 12-month eligibility period. At redetermination, if the family remains eligible, the parent fee is recalculated and is established for the next 12-month eligibility period. A parent fee shall not increase during the 12-month eligibility period. Payment of part or all of a family's parent fee directly to the family's child care provider on behalf of the family by a source other than the family shall not affect the family's eligibility for child care assistance, and the amount paid shall be excluded from the family's income. Child care providers who accept third-party payments must maintain family specific documentation of payment source, amount, and time period covered by the payment.

119B.125 PROVIDER REQUIREMENTS.

Subdivision 1. **Authorization.** Except as provided in subdivision 5, a county or the commissioner must authorize the provider chosen by an applicant or a participant before the county can authorize payment for care provided by that provider. The commissioner must establish the requirements necessary for authorization of providers. A provider must be reauthorized every two years. A legal, nonlicensed family child care provider also must be reauthorized when another person over the age of 13 joins the household, a current household member turns 13, or there is reason to believe that a household member has a factor that prevents authorization. The provider is required to report all family changes that would require reauthorization. When a provider has been authorized for payment for providing care for families in more than one county, the county responsible for reauthorization of that provider is the county of the family with a current authorization for that provider and who has used the provider for the longest length of time.

Subd. 1a. **Background study required.** This subdivision only applies to legal, nonlicensed family child care providers. Prior to authorization, and as part of each reauthorization required in subdivision 1, the county shall perform a background study on every member of the provider's household who is age 13 and older. The county shall also perform a background study on an individual who has reached age ten but is not yet age 13 and is living in the household where the

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nonlicensed child care will be provided when the county has reasonable cause as defined under section 245C.02, subdivision 15.

Subd. 1b. **Training required.** (a) Effective November 1, 2011, prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the county. The training documentation must have valid effective dates as of the date the registration request is submitted to the county. The training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

(b) Legal nonlicensed family child care providers with an authorization effective before November 1, 2011, must be notified of the requirements before October 1, 2011, or at authorization, and must meet the requirements upon renewal of an authorization that occurs on or after January 1, 2012.

(c) Upon each reauthorization after the authorization period when the initial first aid and CPR training requirements are met, a legal nonlicensed family child care provider must provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry.

(d) This subdivision only applies to legal nonlicensed family child care providers.

Subd. 2. **Persons who cannot be authorized.** (a) The provider seeking authorization under this section shall collect the information required under section 245C.05, subdivision 1, and forward the information to the county agency. The background study must include a review of the information required under section 245C.08, subdivisions 2, 3, and 4, paragraph (b). A nonlicensed family child care provider is not authorized under this section if any household member who is the subject of a background study is determined to have a disqualifying characteristic under paragraphs (b) to (e) or under section 245C.14 or 245C.15. If a county has determined that a provider is able to be authorized in that county, and a family in another county later selects that provider, the provider is able to be authorized in the second county without undergoing a new background investigation unless one of the following conditions exists:

- (1) two years have passed since the first authorization;
- (2) another person age 13 or older has joined the provider's household since the last authorization;
- (3) a current household member has turned 13 since the last authorization; or
- (4) there is reason to believe that a household member has a factor that prevents authorization.

(b) The person has refused to give written consent for disclosure of criminal history records.

(c) The person has been denied a family child care license or has received a fine or a sanction as a licensed child care provider that has not been reversed on appeal.

(d) The person has a family child care licensing disqualification that has not been set aside.

(e) The person has admitted or a county has found that there is a preponderance of evidence that fraudulent information was given to the county for child care assistance application purposes or was used in submitting child care assistance bills for payment.

Subd. 3. **Authorization exception.** When a county denies a person authorization as a legal nonlicensed family child care provider under subdivision 2, the county later may authorize that person as a provider if the following conditions are met:

(1) after receiving notice of the denial of the authorization, the person applies for and obtains a valid child care license issued under chapter 245A, issued by a tribe, or issued by another state;

(2) the person maintains the valid child care license; and

(3) the person is providing child care in the state of licensure or in the area under the jurisdiction of the licensing tribe.

Subd. 4. **Unsafe care.** A county may deny authorization as a child care provider to any applicant or rescind authorization of any provider when the county knows or has reason to believe that the provider is unsafe or that the circumstances of the chosen child care arrangement are unsafe. The county must include the conditions under which a provider or care arrangement will be determined to be unsafe in the county's child care fund plan under section 119B.08, subdivision 3.

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Subd. 5. **Provisional payment.** After a county receives a completed application from a provider, the county may issue provisional authorization and payment to the provider during the time needed to determine whether to give final authorization to the provider.

Subd. 6. **Record-keeping requirement.** All providers receiving child care assistance payments must keep daily attendance records at the site where services are delivered for children receiving child care assistance and must make those records available immediately to the county or the commissioner upon request. The attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service. A county or the commissioner may deny authorization as a child care provider to any applicant, rescind authorization of any provider, or establish an overpayment claim in the system against a current or former provider, when the county or the commissioner knows or has reason to believe that the provider has not complied with the record-keeping requirement in this subdivision. A provider's failure to produce attendance records as requested on more than one occasion constitutes grounds for disqualification as a provider.

Subd. 7. **Failure to comply with attendance record requirements.** (a) In establishing an overpayment claim for failure to provide attendance records in compliance with subdivision 6, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) The commissioner may periodically audit child care providers to determine compliance with subdivision 6.

(c) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(d) The commissioner or county shall seek to recoup or recover overpayments paid to a current or former provider.

(e) When a provider has been disqualified or convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recoupment or recovery must be sought regardless of the amount of overpayment.

Subd. 8. **Overpayment claim for failure to comply with access to records requirement.** (a) In establishing an overpayment claim under subdivision 6 for failure to provide access to attendance records, the county or commissioner is limited to the six years prior to the date the county or the commissioner requested the attendance records.

(b) When the commissioner or county establishes an overpayment claim against a current or former provider, the commissioner or county must provide notice of the claim to the provider. A notice of overpayment claim must specify the reason for the overpayment, the authority for making the overpayment claim, the time period in which the overpayment occurred, the amount of the overpayment, and the provider's right to appeal.

(c) The commissioner or county may seek to recover overpayments paid to a current or former provider. When a provider has been convicted of fraud under section 256.98, theft under section 609.52, or a federal crime relating to theft of state funds or fraudulent billing for a program administered by the commissioner or a county, recovery may be sought regardless of the amount of overpayment.

Subd. 9. **Reporting required for child's part-time attendance.** A provider must report to the county and report on the billing form as required when a child's attendance in child care falls to less than half of the child's authorized hours or days for a four-week period. If requested by the county or the commissioner, the provider must provide additional information to the county or commissioner on the attendance of specific children.

119B.13 CHILD CARE RATES.

Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the

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greater of the 25th percentile of the 2011 child care provider rate survey or the maximum rate effective November 28, 2011. For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less. The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

(b) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(c) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

(d) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

(e) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

- (1) the daily rate for one day of care;
- (2) the weekly rate for one week of care by the child's primary provider; and
- (3) two daily rates during two weeks of care by a child's secondary provider.

(f) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

(g) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

(h) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

(i) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.

Subd. 1a. Legal nonlicensed family child care provider rates. (a) Legal nonlicensed family child care providers receiving reimbursement under this chapter must be paid on an hourly basis for care provided to families receiving assistance.

(b) The maximum rate paid to legal nonlicensed family child care providers must be 68 percent of the county maximum hourly rate for licensed family child care providers. In counties or county price clusters where the maximum hourly rate for licensed family child care providers is higher than the maximum weekly rate for those providers divided by 50, the maximum hourly rate that may be paid to legal nonlicensed family child care providers is the rate equal to the maximum weekly rate for licensed family child care providers divided by 50 and then multiplied by 0.68. The maximum payment to a provider for one day of care must not exceed the maximum hourly rate times ten. The maximum payment to a provider for one week of care must not exceed the maximum hourly rate times 50.

(c) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

(d) Legal nonlicensed family child care providers receiving reimbursement under this chapter may not be paid registration fees for families receiving assistance.

Subd. 3. Provider rate for care of children with disabilities or special needs. Counties shall reimburse providers for the care of children with disabilities or special needs, at a special rate to be approved by the county for care of these children, subject to the approval of the commissioner.

Subd. 3a. Provider rate differential for accreditation. A family child care provider or child care center shall be paid a 15 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a

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child development associate credential, a diploma in child development from a Minnesota state technical college, or a bachelor's or post baccalaureate degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation that meets the following criteria: the accrediting organization must demonstrate the use of standards that promote the physical, social, emotional, and cognitive development of children. The accreditation standards shall include, but are not limited to, positive interactions between adults and children, age-appropriate learning activities, a system of tracking children's learning, use of assessment to meet children's needs, specific qualifications for staff, a learning environment that supports developmentally appropriate experiences for children, health and safety requirements, and family engagement strategies. Based on an application process developed by the commissioner in conjunction with the commissioners of education and health, the Department of Human Services must accept applications from accrediting organizations beginning on July 1, 2013, and on an annual basis thereafter. The provider rate differential shall be paid to centers holding an accreditation from an approved accrediting organization beginning on a billing cycle to be determined by the commissioner, no later than the last Monday in February of a calendar year. The commissioner shall annually publish a list of approved accrediting organizations. An approved accreditation must be reassessed by the commissioner every two years. If an approved accrediting organization is determined to no longer meet the approval criteria, the organization and centers being paid the differential under that accreditation must be given a 90-day notice by the commissioner and the differential payment must end after a 15-day notice to affected families and centers as directed in Minnesota Rules, part 3400.0185, subparts 3 and 4. The following accreditations shall be recognized for the provider rate differential until an approval process is implemented: the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.

Subd. 3b. Provider rate differential for Parent Aware. A family child care provider or child care center shall be paid a 15 percent differential if they hold a three-star Parent Aware rating or a 20 percent differential if they hold a four-star Parent Aware rating. A 15 percent or 20 percent rate differential must be paid above the maximum rate established in subdivision 1, up to the actual provider rate.

Subd. 3c. Weekly rate paid for children attending high-quality care. A licensed child care provider or license-exempt center may be paid up to the applicable weekly maximum rate, not to exceed the provider's actual charge, when the following conditions are met:

(1) the child is age birth to five years, but not yet in kindergarten;

(2) the child attends a child care provider that qualifies for the rate differential identified in subdivision 3a or 3b; and

(3) the applicant's activities qualify for at least 30 hours of care per week under sections 119B.03, 119B.05, and 119B.10, and Minnesota Rules, chapter 3400.

Subd. 4. Rates charged to publicly subsidized families. Child care providers receiving reimbursement under this chapter may not charge a rate to clients receiving assistance under this chapter that is higher than the private, full-paying client rate.

Subd. 5. Provider notice. The county shall inform both the family receiving assistance under this chapter and the child care provider of the payment amount and how and when payment will be received. If the county sends a family a notice that child care assistance will be terminated, the county shall inform the provider that unless the family requests to continue to receive assistance pending an appeal, child care payments will no longer be made. The notice to the provider must not contain any private data on the family or information on why payment will no longer be made.

Subd. 6. Provider payments. (a) The provider shall bill for services provided within ten days of the end of the service period. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause

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must be defined in the county's child care fund plan under section 119B.08, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of six months from the date the provider is issued an authorization of care and billing form.

(d) A county or the commissioner may refuse to issue a child care authorization to a licensed or legal nonlicensed provider, revoke an existing child care authorization to a licensed or legal nonlicensed provider, stop payment issued to a licensed or legal nonlicensed provider, or refuse to pay a bill submitted by a licensed or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) a county or the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license; or

(iii) a final order of conditional license issued by the commissioner for as long as the conditional license is in effect;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request; or

(6) the provider gives false child care price information.

(e) For purposes of paragraph (d), clauses (3), (5), and (6), the county or the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 119B.08, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than 25 full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the absent days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

(c) Notwithstanding paragraph (a), children in families may exceed the absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or commissioner of education-selected high school equivalency certification; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon

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request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

(d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the absent days limit.

(e) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

(f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

119B.14 EXTENSION OF EMPLOYMENT OPPORTUNITIES.

The county board shall ensure that child care services available to eligible residents are well advertised and that everyone who receives or applies for MFIP assistance is informed of training and employment opportunities and programs, including child care assistance and child care resource and referral services.

119B.15 ADMINISTRATIVE EXPENSES.

The commissioner shall use up to 1/21 of the state and federal funds available for the basic sliding fee program and 1/21 of the state and federal funds available for the MFIP child care program for payments to counties for administrative expenses. The commissioner shall make monthly payments to each county based on direct service expenditures. Payments may be withheld if monthly reports are incomplete or untimely.

119B.16 FAIR HEARING PROCESS.

Subdivision 1. **Fair hearing allowed.** An applicant or recipient adversely affected by a county agency action may request a fair hearing in accordance with section 256.045.

Subd. 1a. **Fair hearing allowed for providers.** (a) This subdivision applies to providers caring for children receiving child care assistance.

(b) A provider to whom a county agency has assigned responsibility for an overpayment may request a fair hearing in accordance with section 256.045 for the limited purpose of challenging the assignment of responsibility for the overpayment and the amount of the overpayment. The scope of the fair hearing does not include the issues of whether the provider wrongfully obtained public assistance in violation of section 256.98 or was properly disqualified under section 256.98, subdivision 8, paragraph (c), unless the fair hearing has been combined with an administrative disqualification hearing brought against the provider under section 256.046.

Subd. 1b. **Joint fair hearings.** When a provider requests a fair hearing under subdivision 1a, the family in whose case the overpayment was created must be made a party to the fair hearing. All other issues raised by the family must be resolved in the same proceeding. When a family requests a fair hearing and claims that the county should have assigned responsibility for an overpayment to a provider, the provider must be made a party to the fair hearing. The human services judge assigned to a fair hearing may join a family or a provider as a party to the fair hearing whenever joinder of that party is necessary to fully and fairly resolve overpayment issues raised in the appeal.

Subd. 2. **Informal conference.** The county agency shall offer an informal conference to applicants and recipients adversely affected by an agency action to attempt to resolve the dispute. The county agency shall offer an informal conference to providers to whom the county agency has assigned responsibility for an overpayment in an attempt to resolve the dispute. The county agency or the provider may ask the family in whose case the overpayment arose to participate in the informal conference, but the family may refuse to do so. The county agency shall advise adversely affected applicants, recipients, and providers that a request for a conference with the agency is optional and does not delay or replace the right to a fair hearing.

245G.11 STAFF QUALIFICATIONS.

Subdivision 1. **General qualifications.** (a) All staff members who have direct contact must be 18 years of age or older. At the time of employment, each staff member must meet the qualifications in this subdivision. For purposes of this subdivision, "problematic substance use" means a behavior or incident listed by the license holder in the personnel policies and procedures according to section 245G.13, subdivision 1, clause (5).

(b) A treatment director, supervisor, nurse, counselor, student intern, or other professional must be free of problematic substance use for at least the two years immediately preceding employment and must sign a statement attesting to that fact.

(c) A paraprofessional, recovery peer, or any other staff member with direct contact must be free of problematic substance use for at least one year immediately preceding employment and must sign a statement attesting to that fact.

Subd. 4. **Alcohol and drug counselor supervisors.** An alcohol and drug counselor supervisor must:

(1) meet the qualification requirements in subdivision 5;

(2) have three or more years of experience providing individual and group counseling to individuals with substance use disorder; and

(3) know and understand the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be provided by qualified staff. An individual is qualified to provide care coordination if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on care coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A care coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor weekly.

246.18 DISPOSAL OF FUNDS.

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are appropriated to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source; and

(2) funding the operation of the intensive residential treatment service program in Willmar.

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622 and operating under section 246.014.

254B.03 RESPONSIBILITY TO PROVIDE CHEMICAL DEPENDENCY TREATMENT.

Subd. 4a. **Division of costs for medical assistance services.** Notwithstanding subdivision 4, for chemical dependency services provided on or after October 1, 2008, and reimbursed by medical assistance, the county share is 30 percent of the nonfederal share.

256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

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

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

256I.05 MONTHLY RATES.

Subd. 3. **Limits on rates.** When a room and board rate is used to pay for an individual's room and board, the rate payable to the residence must not exceed the rate paid by an individual not receiving a room and board rate under this chapter.

256R.53 FACILITY SPECIFIC EXEMPTIONS.

Subd. 2. **Nursing facility in Breckenridge.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the city of Breckenridge, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by

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the commissioner, for the equivalent case mix indices of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate with a case mix index of 1.0 is computed by dividing the adjacent city's nursing facility or facilities' median operating payment rate with an index of 1.02 by 1.02.

Laws 2017, First Special Session chapter 6, article 7, section 34

Sec. 34. MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT PROJECT.

Subdivision 1. **Authorization.** The commissioner of human services may develop a pilot project that shall test an alternative financing model for the distribution of publicly funded benefits. The commissioner may work with interested counties to develop the pilot and determine the waivers that are necessary to implement the pilot project based on the pilot design in subdivisions 2 and 3, and outcome measures in subdivision 4.

Subd. 2. **Pilot project goals.** The goals of the pilot project are to:

(1) reduce the historical separation among the state programs and systems affecting families who are receiving public assistance;

(2) eliminate, where possible, funding restrictions to allow a more comprehensive approach to the needs of the families in the pilot project; and

(3) focus on upstream, prevention-oriented supports and interventions.

Subd. 3. **Project participants.** The pilot project developed by the commissioner may include requirements that participants:

(1) be 26 years of age or younger with a minimum of one child;

(2) voluntarily agree to participate in the pilot project;

(3) be eligible for, applying for, or receiving public benefits including but not limited to housing assistance, education supports, employment supports, child care, transportation supports, medical assistance, earned income tax credit, or the child care tax credit; and

(4) be enrolled in an education program that is focused on obtaining a career that will likely result in a livable wage.

Subd. 4. **Outcomes.** The outcome measures for the pilot project must include:

(1) improvement in the affordability, safety, and permanence of suitable housing;

(2) improvement in family functioning and stability, including in the areas of behavioral health, incarceration, involvement with the child welfare system, or equivalent indicators;

(3) improvement in education readiness and outcomes for parents and children from early childhood through high school, including reduction in absenteeism, preschool readiness scores, third grade reading competency, graduation, GPA, and standardized test improvement;

(4) improvement in attachment to the workforce of one or both parents, including enhanced job stability; wage gains; career advancement; progress in career preparation; or an equivalent combination of these or related measures; and

(5) improvement in health care access and health outcomes for parents and children.

3400.0010 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose.** The purpose of this chapter is to govern the administration of the child care fund, to reduce, according to a sliding fee schedule, the costs of child care services for eligible families to enable them to seek or retain employment or to participate in education or training programs to obtain employment, and to provide eligible families with the financial resources to find and afford quality child care for their children. This chapter sets eligibility standards for recipients and administrative requirements for agencies administering child care funds.

Subp. 2. **Applicability.** This chapter applies to all county and human service boards providing child care assistance to eligible families under Minnesota Statutes, sections 119B.011 to 119B.16.

3400.0020 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 3400.0010 to 3400.0230, the terms defined in Minnesota Statutes, section 119B.011, have the meanings given them in that section, and the following terms have the meanings given them in this part.

Subp. 4. **Administering agency.** "Administering agency" means a county social services agency or a public or nonprofit agency designated by the county board to administer the child care fund.

Subp. 5. **Administrative expenses.** "Administrative expenses" means costs associated with the direct services administration of the child care fund. Administrative expenses include:

- A. salaries, wages, and related payroll expenses incurred in the administration of the child care fund including direct personnel costs, expenses for general administration and supervision, and expenses for secretarial, clerical, accounting, and other support services;
- B. travel and transportation and per diem or subsistence expenses;
- C. expenses for materials and office supplies;
- D. publication, telephone, postage, and photocopy expenses; and
- E. other expenses directly attributable to the child care fund.

Subp. 8. **Allocation.** "Allocation" means the share of the total state appropriation of child care funds that a county may earn and be reimbursed for in an allocation period. A county's allocation may be raised or lowered during the allocation period when the commissioner redistributes unexpended or unencumbered allocations or when additional funds become available.

Subp. 9a. **At-risk.** "At-risk" means environmental or familial factors that create barriers to a child's optimal achievement. Factors include, but are not limited to, a federal or state disaster, limited English proficiency in a family, a history of abuse or neglect, a determination that the children are at risk of abuse or neglect, family violence, homelessness, age of the mother, level of maternal education, mental illness, developmental disability, or parental chemical dependency or history of other substance abuse.

Subp. 10a. **Authorized hours.** "Authorized hours" means the number of hours in a service period, not to exceed the maximum hour limit established in Minnesota Statutes, section 119B.09, subdivision 6, that may be paid for child care for a child.

Subp. 12. **Child care assistance.** "Child care assistance" means financial assistance for child care that is funded under Minnesota Statutes, sections 119B.011 to 119B.16.

Subp. 17a. **Disability.** "Disability" means a functional limitation or health condition that interferes with a child's ability to walk, talk, see, hear, breathe, or learn.

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Subp. 18. **Documentation.** "Documentation" means a written statement or record, including an electronic record, that substantiates or validates an assertion made by a person or an action taken by an administering agency.

Subp. 18a. **DWP.** "DWP" means the diversionary work program established in Minnesota Statutes, section 256J.95.

Subp. 20. **Eligible relative caregiver.** "Eligible relative caregiver" means a person identified under Minnesota Statutes, section 256J.08, subdivision 11, (1) who is a caregiver of a child receiving a MFIP grant or (2) who is an MFIP participant and the caregiver of a child. After an eligible relative caregiver begins receiving child care assistance, status as an eligible relative caregiver continues through all child care assistance programs until there is a break in the eligible relative caregiver's eligibility for child care assistance.

Subp. 24. **Family copayment fee.** "Family copayment fee" means the parent fee the family must contribute as its share of child care costs as determined under Minnesota Statutes, section 119B.12.

Subp. 25. **Full calendar month.** "Full calendar month" from the first day of a month to the last day of that month.

Subp. 26. **Full-day basis.** "Full-day basis" means child care provided by a provider for more than five hours per day.

Subp. 28. **Household status.** "Household status" means the number of individuals residing in the household and the relationship of the individuals to one another.

Subp. 29a. **Immunization record.** "Immunization record" means the statement described in Minnesota Statutes, section 121A.15, subdivision 1, 3, paragraph (c) or (d), or 4.

Subp. 31b. **Legal guardian.** "Legal guardian" means a person who has been appointed or accepted as a guardian according to Minnesota Statutes, section 260C.325, 524.5-201, 524.5-202, or 524.5-204 under tribal law.

Subp. 32b. **Minimum wage.** "Minimum wage" means the minimum wage applicable under Minnesota Statutes, chapter 177, to the applicant or participant or the premises where the applicant or participant is employed.

Subp. 33. **Overpayment.** "Overpayment" means the portion of a child care payment that is greater than the amount for which a recipient is eligible or greater than the amount a provider should have received.

Subp. 34a. **Participant.** "Participant" means a family receiving child care assistance under the child care fund.

Subp. 35. **Provider rate.** "Provider rate" means the amount the provider charges for child care.

Subp. 37. **Redetermination.** "Redetermination" means the process by which information is collected periodically by the county and used to determine whether a recipient is eligible for continued assistance under the child care fund.

Subp. 38. **Registration.** "Registration" means the process used by the county to obtain from a legal nonlicensed provider the information required under part 3400.0120, subpart 2.

Subp. 38a. **Residence.** "Residence" means the primary place where the family lives as identified by the applicant or participant.

Subp. 38b. **Scheduled hours.** "Scheduled hours" means the specific days and hours during a service period that a child will attend child care as determined by the child care worker, the parent, and the provider based on the parents' verified eligible activities schedules, the child's school schedule, and any other factors relevant to the family's child care needs.

Subp. 39. **State median income.** "State median income" means the state's annual median income for a family of three, adjusted for family size, developed by the Bureau of Census and published annually by the United States Department of Health and Human Services in the Federal Register.

Subp. 40. **Student.** "Student" means an individual enrolled in an educational program as defined in Minnesota Statutes, section 119B.011, subdivision 11. A non-MFIP student is a full-time student if the student is defined by the student's educational institution as a full-time student. A non-MFIP student is a part-time student if the student is defined by the student's educational institution as a part-time student. A MFIP student is a student who is in compliance with the education or training requirements in the student's employment plan.

Subp. 40a. **Temporarily absent.** "Temporarily absent" means a family member is living away from the family's residence but intends to return to the residence.

Subp. 44. **Weekly basis.** "Weekly basis" means child care provided by a provider for more than 35 but not more than 50 hours per week.

3400.0030 NOTICE OF BASIC SLIDING FEE PROGRAM ALLOCATION.

By July 1 of each year, the commissioner shall notify all county and human services boards of their allocation under the basic sliding fee program, including the amount available for payment of administrative expenses.

3400.0035 APPLICATION PROCEDURE.

Subpart 1. **Response to informational requests.** When a family asks for information about child care assistance, the administering agency must give the family information supplied by the department regarding the availability of federal and state child and dependent care tax credits; federal earned income tax credits; Minnesota working family credits; early childhood family education, school readiness, and Head Start programs; early childhood screening; MinnesotaCare; child care resource and referral services; other programs with services for young children and families; and the postsecondary child care grant program established in Minnesota Statutes, section 136A.125. The administering agency also must inform the family of the following items:

- A. the eligibility requirements under the child care fund;
- B. the documentation necessary to confirm eligibility;
- C. whether a waiting list exists and, if so, the number of families on the waiting list or the estimated time that the applicant will spend on the waiting list before reaching the top of the list;
- D. the procedure for applying for child care assistance;
- E. the family copayment fee schedule and how the fee is computed;
- F. information about how to choose a provider;
- G. the family's rights and responsibilities when choosing a provider;
- H. information about the availability of special needs rates;
- I. the family's responsibility for paying provider charges that exceed county maximum payments in addition to the family copayment fee; and
- J. the importance of prompt reporting of a move to another county to avoid overpayments and to increase the likelihood of continuing benefits, because child care assistance benefits may be affected by moving to another county.

Subp. 2. **Application procedure.** An administering agency must follow the application procedures in items A and B.

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A. If a family requests child care assistance and it appears that the family is eligible for child care assistance and funds are available, or if a family requests an application, the administering agency must mail or hand the family a universal child care assistance application.

B. If a family requests child care assistance and funds are not available, the administering agency must inform the family of a waiting list, screen the family for potential eligibility, and place the family on the waiting list if they appear eligible. The administering agency must place the family on the waiting list in the highest priority for which the family is eligible. As child care funds become available, the administering agency must inform the family at the head of the waiting list and ask the family to complete an application.

C. The administering agency must accept signed and dated applications that are submitted by mail or delivered to the agency within 15 calendar days after the date of signature. A county may accept an application from an applicant who does not reside in that county but immediately must forward the application to the county where the applicant resides. The administering agency must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. With the consent of the applicant, the administering agency may extend the response time by 15 calendar days.

Subp. 3. **Informational release.** When it appears that an applicant may be eligible for child care assistance but is unable to document eligibility for the program, the administering agency must offer an applicant the opportunity to sign an informational release to permit the county to verify whether an applicant qualifies for child care assistance. The administering agency must also offer an applicant an opportunity to sign an informational release to permit the county to give the family's child care provider the information listed in subpart 6 and in part 3400.0185, subparts 2 and 4, that is not required by Minnesota Statutes, section 119B.13, subdivision 5. The administering agency must give the applicant the information required by Minnesota Statutes, section 13.04, subdivision 2.

Subp. 4. **Notice of denial.** If the administering agency denies the application, the administering agency must document the reason or reasons for denying the application. The administering agency must provide written notice to the applicant of: the reason for denial; the provision in statute, rule, or county child care fund plan that is the basis for the denial; and the applicant's right to a fair hearing under part 3400.0230 and Minnesota Statutes, section 119B.16.

Subp. 5. **Notice of approval.** If the administering agency approves the application, the administering agency must send the applicant a notice of approval of the application. The notice of approval must specify the information in items A to I:

- A. the beginning date of eligibility;
- B. the hours of care authorized, the maximum rate that may be paid, and how payments will be made;
- C. the copayment amount including how and when the copayment must be made;
- D. any change in income, residence, family size, family status, or employment, education, or training status must be reported within ten calendar days from the date the change occurs;
- E. except in cases where the license of a provider licensed by the state of Minnesota has been temporarily immediately suspended or where there is an imminent risk of harm to the health, safety, or rights of a child in care with a legal nonlicensed provider, license exempt center, or a provider licensed by an entity other than the state of Minnesota, any change in provider must be reported to the county and the provider at least 15 calendar days before the change occurs;
- F. the overpayment implications for the family if the changes described in items D and E are not reported as required;

G. when child care assistance is terminated, the participant will be informed of the reason for the termination and the participant's appeal rights and the provider will be informed that, unless the family asks to continue to receive assistance pending an appeal, child care payments will no longer be made;

H. the importance of prompt reporting of a move to another county to avoid overpayments and increase the likelihood of continuing benefits, because child care assistance benefits may be affected by moving to another county; and

I. the family's responsibility for paying provider charges that exceed county maximum payments in addition to the family copayment fee.

Subp. 6. **Notice to provider.** If the administering agency approves an application, the administering agency must send the family's authorized provider a notice containing only the following information: the family's name; the fact that the family's request for child care assistance has been approved; the hours of care authorized; the maximum rate that may be paid by the child care assistance program; the number of absent days that have been paid for the child for the year as of the date of the notice; and how payments will be made.

Subp. 7. **Selection of provider.** An applicant must select a provider before payments can be made from the child care fund.

Subp. 8. **Selection of legal nonlicensed provider.** An applicant who selects a legal nonlicensed provider must be informed about the following information and must sign an acknowledgment that contains:

- A. a description of the registration process for legal nonlicensed providers;
- B. a description of the parent's rights and responsibilities when choosing a provider;
- C. an acknowledgment that the parent and the legal nonlicensed provider have reviewed the health and safety information provided by the county; and
- D. if the parent has selected a legal nonlicensed family child care provider, an assurance that the parent will provide an immunization record for each child to the legal nonlicensed family child care provider within 90 days of the date that care for the child begins and will give the legal nonlicensed family child care provider the information necessary to update the immunization record.

Subp. 9. **Selection of in-home provider.** An applicant who selects a provider who will provide child care in the applicant's home must be informed that this choice of care may create an employer/employee relationship between the parent and the provider and must be referred to resources available for more information about these legal rights and responsibilities.

3400.0040 ELIGIBILITY REQUIREMENTS AND STANDARDS.

Subpart 1. **Applicant requirements and standards.** All applicants for child care assistance and all child care assistance program participants must meet the standards and requirements in this part in addition to the eligibility requirements in part 3400.0060, 3400.0080, or 3400.0090 for the child care program for which the person is applying or in which the person is participating.

Subp. 3. **Documentation of eligibility information.**

- A. An applicant for child care assistance must document the:
 - (1) citizenship status or participation in a program that makes a child exempt from this documentation requirement for all children for whom child care assistance is being sought;
 - (2) relationship of the children in the family to the applicant;
 - (3) date of birth of the children in the family;

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(4) date of birth of the applicant if the applicant is under 21 years of age;

(5) identity, income eligibility, and residence for all members of the applicant's family, including members temporarily absent from the household as defined in part 3400.0020, subpart 40a; and

(6) work, education, or training activity status for all applicants as defined in Minnesota Statutes, section 119B.011, subdivision 2.

B. The county must ask for the applicant's Social Security number, but the applicant is not required to disclose this information. Before asking for the applicant's social security number, the county must tell the applicant that:

(1) the disclosure is voluntary;

(2) the number is being solicited under the Code of Federal Regulations, title 45, section 98.71(a)(13); and

(3) the social security number will be used by county, state, and federal governments and their employees for the purposes of verification, reporting, research, and any other purpose authorized by law.

C. The county must determine an applicant's eligibility for child care assistance at the time of application. The county must redetermine eligibility according to part 3400.0180.

Subp. 4. **Participant reporting responsibilities.** A participant must meet the reporting requirements in items A and B. A participant may report a change in person, by telephone, by facsimile, or by mail, including electronic mail.

A. When there is a change in the information reported by the participant at application or at the most recent redetermination of eligibility, the participant must report the new information to the county within ten calendar days after the change occurs. This reporting requirement applies to changes in income, residence, employment status, education or training status, family status, or family size. A change in income occurs on the day the participant receives the first payment reflecting the change in income.

B. Except in cases where the license of a provider licensed by the state of Minnesota has been temporarily immediately suspended or where there is an imminent risk of harm to the health, safety, or rights of a child in care with a legal, nonlicensed provider, license exempt center, or provider licensed by an entity other than the state of Minnesota, a participant must notify the county and the provider of the intent to change providers at least 15 calendar days before changing providers.

Subp. 5. **Employment, education, and training requirements.** In a family with a single parent, or unmarried legal guardian or eligible relative caregiver, the applicant or participant must meet employment, education, or training requirements and other eligibility requirements in this part and in part 3400.0060, 3400.0080, or 3400.0090 for the child care assistance program for which the family is applying or in which the family is participating.

In a family with more than one parent or any combination of parents, stepparents, legal guardians and spouses, and eligible relative caregivers and spouses, at least one parent, legal guardian, eligible relative caregiver, or spouse must meet employment, education, or training requirements and other eligibility requirements in this part and in part 3400.0060, 3400.0080, or 3400.0090 for the child care assistance program for which the family is applying or participating in. The other parents, legal guardians, eligible relative caregivers, or spouses must:

A. meet employment, education, or training requirements and other eligibility requirements in this part and part 3400.0060, 3400.0080, or 3400.0090 for the child care assistance program for which the family is applying or participating in; or

B. be unable to care for the applicant's child or dependent as determined by a licensed physician, licensed psychologist, or the local social services agency.

Subp. 5a. **Child support cooperation.** All applicants and participants of the child care assistance program must cooperate with establishment of paternity and enforcement of child support obligations for all minor children in the family with an absent parent. For purposes of this part, a family has met the cooperation requirement when the family complies with Minnesota Statutes, section 256.741, or there is a finding under Minnesota Statutes, section 256.741, subdivision 10, of good cause for failing to cooperate. The child care portion of the child support order for children receiving child care assistance must be assigned to the public authority as provided in Minnesota Statutes, section 256.741.

Subp. 6a. **Ineligibility for failure to pay fees under the child care fund.** A family that fails to pay the required family copayment fee under the child care fund is ineligible for child care assistance until the fees are paid or until the family reaches an agreement for payment with the provider and the county and then continues to comply with the payment agreement. When the county pays the parent, a family that fails to pay the provider the amount of the child care assistance payment is ineligible for child care assistance until the payment is made or until the family reaches an agreement for payment with the provider and the county and then continues to comply with the payment agreement.

Subp. 6b. **Ineligibility for failure to pay overpayments.** A family with an outstanding overpayment is ineligible for child care assistance until the overpayment is paid in full or until the family arranges to repay the overpayment according to part 3400.0187 and then continues to comply with the repayment agreement.

Subp. 6c. **Date of eligibility for assistance.** The date of eligibility for child care assistance under parts 3400.0060 and 3400.0080 must be determined according to Minnesota Statutes, section 119B.09, subdivision 7. The date of eligibility for child care assistance under part 3400.0090 is the date the family's MFIP or DWP case was closed.

Subp. 7. **Maximum biweekly child care assistance.** A family may not receive more than 120 hours of child care assistance per child every two weeks.

Subp. 8. **Child care assistance during employment.**

A. In addition to meeting other eligibility requirements, employed persons eligible for child care assistance under part 3400.0060, 3400.0080, or 3400.0090 must work at least an average of 20 hours per week and receive at least the minimum wage for all hours worked. Employed persons eligible for child care assistance under part 3400.0080 are exempt from this requirement if they have an approved employment plan that allows fewer work hours or a lower wage.

B. The county and the participant may determine a length of time, not to exceed six months, over which the number of hours worked weekly can be averaged and counted toward the participant's meeting the average of 20 hours per week requirement. If the number of hours worked during the designated time period actually averages less than 20 hours per week, any child care assistance funds paid by the county on the participant's behalf during the designated time period are subject to recoupment or recovery.

C. When a participant does not work by the hour and is not paid an hourly wage, the participant's earned income over a given period must be divided by the minimum wage to determine whether the participant has met the requirement to average at least 20 hours of work per week at minimum wage.

D. Child care assistance during employment shall be authorized for the number of hours scheduled to be worked, including break and meal time during the employment, and up to two hours per day for travel time.

Subp. 9. **Child care assistance in support of employment.** A county must authorize child care assistance in support of employment for nonwork hours when the following conditions exist:

A. the employee cannot reasonably modify his or her nonwork schedule to provide child care; and

B. the child care assistance does not exceed the amount of assistance that would be granted under subpart 8, item D, during employment.

Subp. 10. **Child care assistance during education or training.** Counties shall provide child care assistance to students eligible under part 3400.0060 or 3400.0080 and enrolled in county-approved education or training programs or employment plans according to items A to C.

A. Counties must authorize child care for full-time students for the days of class and on nonclass days, if needed for study, as determined by the county, not to exceed the maximum biweekly child care allowed.

B. Counties must authorize child care for part-time students as needed for:

(1) all hours of actual class time and credit hours for independent study and internships;

(2) time periods between nonconsecutive classes;

(3) up to two hours per day for travel time; and

(4) two hours per week per credit hour for postsecondary students for study and academic appointments.

When a part-time student has more than one hour between classes on any one day, the study and academic appointment time authorized under subitem (4) shall be reduced by the number of hours between classes.

C. Child care assistance for remedial classes is subject to county approval under subpart 12. Upon county approval of the remedial class or classes, the county shall authorize child care assistance necessary to enable the student to attend class and to complete class assignments.

Subp. 11. **Child care assistance during employment and education or training.** Employed students, including students on work study programs, are eligible for child care assistance during employment and education or training. Counties shall use the standards in subparts 8 and 10 to determine the amount of child care assistance. When full-time students request child care for employment, the employment hours must average at least ten hours per week at minimum wage. For purposes of determining whether the ten hours at minimum wage requirement in this subpart applies to a student, a full-time student retains full-time status during school breaks, including summers, if the student is expected to return to school full time after the break. Students eligible for child care assistance under part 3400.0080 are exempt from the ten hours per week at minimum wage requirement if they have an approved employment plan that allows fewer work hours or a lower wage. For purposes of determining whether the ten hours at minimum wage requirement in this subpart has been met, work-study hours and income must be counted as employment.

Subp. 12. **Acceptable course of study.** An acceptable course of study for a student eligible under part 3400.0060 is an education or training program approved by the county that will reasonably lead to full-time employment opportunities as determined by the county. An acceptable course of study for a student eligible under part 3400.0080 is an approved education or training program described in the MFIP participant's employment plan.

Subp. 13. **Satisfactory progress in education or training program.** Subject to the limitation in subpart 14, a county shall provide child care assistance to students with an approved education or training program for the length of the education or training program if the student is making satisfactory progress in the education or training program. Satisfactory progress in the education or training program means a student remains in good academic standing in the education or training program as determined by the educational institution and meets the requirements of the student's education plan under part 3400.0060

or employment plan under part 3400.0080. If the county determines that a student is not making satisfactory progress towards completion of an education or training program, the county shall notify the student and discontinue child care assistance according to part 3400.0185.

Subp. 14. **Maximum education or training under child care fund.** The maximum length of time a student is eligible for child care assistance under the child care fund for education or training is described in items A to D.

A. A student eligible under part 3400.0060 is eligible for child care assistance according to Minnesota Statutes, section 119B.07.

B. A student eligible under part 3400.0080 is eligible for child care assistance for the length of time necessary to complete activities authorized in the student's employment plan according to the standards in Minnesota Statutes, chapter 256J.

C. A student eligible under part 3400.0060 who has completed or who has participated in but failed to complete an education or training program under the child care fund may receive child care assistance for a second education or training program if:

- (1) the new education or training program is approved by the county; and
- (2) the county expects that completing the program will lead to full-time employment.

D. A student eligible under part 3400.0060 with a baccalaureate degree may only obtain child care assistance for education or training if the education or training is for continuing education units, certification, or coursework that is related to the baccalaureate degree or current employment and that is necessary to update credentials to obtain or retain employment.

Subp. 15. **Changes in education or training programs.** A proposed change in an education or training program is subject to county approval before the change may be made. A county may not deny a request for a change in an education or training program when the student requesting the change can show that changing a course or focus of study is necessary for reasons related to the health and safety of the student.

Subp. 15a. **Child care assistance during job search.**

A. A county shall provide up to 240 hours per calendar year of child care assistance for job search activities to participants:

- (1) eligible under part 3400.0080 who do not have approved job search support plans or whose approved employment plans do not include job search as an authorized activity;
- (2) eligible under part 3400.0090 who are seeking employment; and
- (3) eligible under part 3400.0060 who are seeking employment.

B. The county shall grant child care assistance for job search activities:

- (1) according to the number of hours in the individual's approved job search plan;
- (2) by applying the criteria identified in its child care fund plan; or
- (3) by verifying the actual number of hours spent on job search.

C. At the option of the individual in job search and with prior county approval, child care may be used at a rate that is less than full time provided the total child care assistance does not exceed 240 hours of child care per calendar year.

D. Job search includes locating and contacting potential employers, preparing for interviews, interviewing, and up to two hours of travel time per day.

Subp. 17. **Temporary ineligibility.** Counties must reserve a family's position under the child care assistance fund if a family has been receiving child care assistance but is temporarily ineligible for assistance. A county may reserve a family's position under the child care assistance fund if a family is approved to receive child care assistance and reaches the top of the waiting list but is temporarily ineligible for assistance. In its child care fund plan, a county must specify whether it reserves positions under the child care assistance fund for temporarily ineligible families who reach the top of the waiting list and, if so, the criteria used to make the decision whether to reserve a position. Employed participants may be temporarily ineligible for a maximum of 90 days. Child care assistance participants who are students may be temporarily ineligible for a maximum of one academic quarter or semester as determined by the educational institution.

Subp. 18. **Suspension.** Counties must suspend, and may not terminate, a family's child care assistance for up to one continuous year if there are temporary breaks when child care assistance is not needed or the family does not have an authorized provider but the family remains eligible for child care assistance.

3400.0060 BASIC SLIDING FEE PROGRAM.

Subp. 2. **Basic sliding fee allocation.** The commissioner shall allocate child care funds for the basic sliding fee program as provided in Minnesota Statutes, section 119B.03, subdivisions 6 to 9.

Subp. 4. **Reallocation of unexpended or unencumbered funds.** The commissioner shall reallocate unexpended or unencumbered funds according to items A to D.

A. The commissioner may reallocate unexpended or unencumbered funds following the first, second, and third quarters of the allocation period as provided in Minnesota Statutes, section 119B.03, subdivision 5. Following the fourth quarter of the allocation period, the commissioner shall review county expenditures under the basic sliding fee program and shall reallocate unearned allocations to counties that had direct service earnings in excess of their allocation.

B. The amount reallocated to any county shall be based on direct service earnings in excess of its allocation. The amount reallocated shall not be greater than the direct service earnings in excess of allocation minus the county's fixed local match to be calculated as specified in Minnesota Statutes, section 119B.11, subdivision 1.

C. If the amount of funds available for reallocation is less than total county direct service earnings in excess of allocations, the reallocated funds shall be prorated to each county based on the ratio of the county's direct service earnings in excess of its allocation to the total of all county direct service earnings in excess of their allocation.

D. If the amount of funds available for reallocation is greater than total county direct service earnings in excess of allocations under the basic sliding fee program, the funds remaining after the basic sliding fee reallocation shall be carried forward and added to the funds available for allocation in the next allocation period.

Subp. 5. **Families eligible for assistance under the basic sliding fee program.** To the extent of available allocations, a family is eligible for child care assistance under the basic sliding fee program if:

A. the applicant meets eligibility requirements under part 3400.0040;

B. the applicant is not a MFIP or DWP participant; and

C. the family meets the income eligibility requirements specified in Minnesota Statutes, section 119B.09.

Subp. 6. **Basic sliding fee program waiting lists.** Counties must keep a written record of families who have requested child care assistance. When a family requests information about child care assistance, the county shall perform a preliminary determination of eligibility.

If it appears that a family is or will be eligible for child care assistance and funds are not immediately available, the family shall be placed on a child care waiting list. The county must determine the highest priority group for which a family qualifies and must notify the family of this determination.

Families who inquire or apply while they are temporarily ineligible shall be placed on the waiting list if it appears they will be eligible for child care assistance. When a family advances to the top of the county's waiting list and is temporarily ineligible for child care assistance, the county shall leave the family at the top of the list according to priority group and serve the applicant who is next on the waiting list unless a different procedure is provided in the county's child care fund plan.

Subp. 6a. **Transfer of families from waiting list to basic sliding fee program.** Families on the basic sliding fee waiting list shall be moved into the basic sliding fee program as funding permits according to the priorities listed in Minnesota Statutes, section 119B.03. After the county has complied with the priority requirement in section 119B.03, the county must comply with any priority requirements adopted under part 3400.0140, subpart 10, to move families on the waiting list into the basic sliding fee program.

Subp. 7. **Waiting list; transfer of transition year families to the basic sliding fee program.**

A. The county shall place transition year families on the county's basic sliding fee program waiting list effective on the date the family became eligible for transition year child care assistance.

B. If a transition year family moves to a new county, the date the family was placed on the basic sliding fee waiting list in the original county shall transfer with the family.

C. Families who are eligible for, but do not use, transition year child care assistance retain their priority status for the basic sliding fee program. Families lose their priority status at the conclusion of their transition year.

D. The county shall manage its basic sliding fee allocation in a way that allows families to move from transition year to the basic sliding fee program without any interruption in services. The county shall not serve families who are a lower priority on the basic sliding fee waiting list than a transition year family unless the county can ensure basic sliding fee program funding for the transition year family at the end of the transition year.

E. When the transition year ends, the county shall move the transition year family into the basic sliding fee program. A transition year family that does not come to the top of the county's basic sliding fee program waiting list before completion of the transition year shall be moved into the basic sliding fee program as funding becomes available according to the priority under Minnesota Statutes, section 119B.03, subdivision 4. Transition year extension child care may be used to support employment or a job search that meets the requirements of Minnesota Statutes, section 119B.10, for the time necessary for the family to be moved from the basic sliding fee waiting list into the basic sliding fee program.

Subp. 8. **Application for child care assistance.** A family must apply for child care assistance in the family's county of residence.

Subp. 9. **County child care responsibility when family moves.**

A. When a family receiving child care assistance from the basic sliding fee program moves to a new county within Minnesota, the original county must continue to provide child care assistance for two full calendar months after the move if the family needs child care and remains eligible for the basic sliding fee program. The family is responsible for notifying the new county of residence within 60 days of moving and applying for basic sliding fee assistance in the new county. The limitation in Minnesota Statutes, section 119B.09, subdivision 1, paragraph (a), clause (2), regarding the family's household income at program

entry does not apply when a family receiving assistance moves to another county and timely applies under this item to continue receiving assistance in the new county.

B. If there is a waiting list for the basic sliding fee program in the receiving county when it assumes responsibility for the family, the receiving county must fund child care assistance for the family through the portability pool. Portability pool funding must continue for the lesser of six months or until the family is able to receive assistance under the receiving county's basic sliding fee program. The family must also be added to the basic sliding fee program waiting list according to portability pool priority group in the receiving county effective the date of the move. If the family reaches the top of the waiting list and funds become available before the six months have ended, the receiving county must immediately add the family to its basic sliding fee program. If basic sliding fee funds are not available when the six months has ended, services to the family must be terminated. The family must stay on the waiting list effective the date of the move. If funds become available after the family's child care assistance has been terminated due to the end of the portability pool period, the family must be treated as a new applicant and must have a household income that meets the income requirements in Minnesota Statutes, section 119B.09, subdivision 1, for program entry.

C. If there is no waiting list for the basic sliding fee program and funds are available, the receiving county must immediately move the family into its basic sliding fee program when it assumes responsibility for the family according to Minnesota Statutes, section 256G.07.

D. If the participant had an approved educational plan in the original county, the plan transfers with the participant. The plan remains in effect during the two months that the original county continues to pay for the family's child care assistance and during any time the family's child care assistance is paid through the portability pool. When the receiving county pays the family's basic sliding fee assistance from its own allocation, the receiving county may reject, approve, or modify the family's educational plan based on the receiving county's criteria for approving educational plans.

Subp. 10. **Continued eligibility under basic sliding fee program.** A county may not refuse continued child care assistance to a family receiving assistance under the basic sliding fee program when there is a change in the family's financial or household status provided that the family continues to meet the eligibility requirements in this part and the general eligibility requirements in part 3400.0040. Except for the job search time limit under Minnesota Statutes, section 119B.10, subdivision 1, paragraph (a), the education time limit in Minnesota Statutes, section 119B.07; and the time limit for the at-home infant care program in Minnesota Statutes, section 119B.035, subdivision 4, counties may not set a time limit for eligibility under the basic sliding fee program.

3400.0080 MFIP CHILD CARE PROGRAM.

Subpart 1. **Eligibility for MFIP child care program.** Persons listed in Minnesota Statutes, section 119B.05, subdivision 1, are eligible for the MFIP child care assistance program.

Subp. 1a. **Eligibility of sanctioned MFIP participant.** A MFIP participant eligible for child care assistance who has been sanctioned under the MFIP program may receive child care assistance:

A. for that portion of the participant's job search support or employment plan which the participant is complying with according to Minnesota Statutes, chapter 256J; or

B. according to Minnesota Statutes, section 119B.05, subdivision 1, clause (1).

Subp. 1b. **Child care assistance for approved job search.** A MFIP participant who has an approved job search support plan or whose employment plan includes job search as an authorized activity is not limited to 240 hours of job search child care assistance in a calendar year.

Subp. 8. **County responsibility when a family moves to another county.** When a MFIP or DWP participant moves to a new county and the new county accepts responsibility for the participant's approved job search support or employment plan under Minnesota Statutes, section 256J.55, subdivision 3, the new county is responsible for providing child care assistance to the MFIP or DWP participant effective on the date that the county accepted responsibility for the plan. In all other cases, child care assistance must be provided according to Minnesota Statutes, section 256G.07, when a MFIP or DWP participant moves to a new county.

3400.0090 TRANSITION YEAR CHILD CARE.

Subpart 1. **Notice to family of eligibility.** The administering agency must notify a family, in writing, at the time the family's MFIP or DWP case closes of the family's potential eligibility for transition year child care. The notification must include information on how to establish eligibility for transition year child care and on the family's rights and responsibilities under the transition year child care program.

Subp. 2. **Eligibility.** Transition year child care assistance may only be used to support employment and job search related expenses. A family is eligible for transition year child care if the conditions in items A to D are met.

A. The family's MFIP or DWP case has closed.

B. At least one caregiver in the family received MFIP or DWP in at least three of the six months immediately preceding the month in which the family's MFIP or DWP case was closed.

C. The family meets the income eligibility requirements specified in Minnesota Statutes, section 119B.09, subdivision 1.

D. Transition year child care may be paid for the care of a child who would have been eligible to receive a MFIP grant, or for children who would have been eligible for MFIP, except for the child's receipt of SSI or Title IV-E foster care benefits.

Eligibility for transition year child care begins the first month after the family's MFIP or DWP case has closed and continues for 12 consecutive months. A family's temporary ineligibility for, suspension of, or failure to use child care assistance during the transition year does not suspend the transition year period. A former MFIP or DWP participant may apply for transition year child care any time during the transition year and, notwithstanding the application date, shall receive retroactive transition year child care assistance according to Minnesota Statutes, section 119B.09, subdivision 7. If a family was receiving child care assistance when the family's MFIP or DWP case closed, determination of eligibility for transition year child care assistance must be treated as a redetermination rather than a new application.

Subp. 3. **Loss of transition year child care eligibility.** A family in which all caregivers have been disqualified from receiving MFIP or DWP due to fraud is not eligible for transition year child care assistance.

Subp. 4. **Reestablishment of MFIP or DWP eligibility during transition year period.** If a transition year family reopens its MFIP or DWP case during the transition year period and subsequently meets the conditions in subpart 2, the family qualifies for a new 12-month transition year period. If the family received MFIP or DWP for only one or two of the previous six months, but meets the requirements in subpart 2, items A, C, and D, the family is eligible for the remaining months of the transition year, treating the month or months on MFIP or DWP as a suspension of the child care benefit but not the transition year period. To receive child care assistance while receiving MFIP or DWP, the family must meet the MFIP child care requirements under part 3400.0080.

3400.0100 FAMILY COPAYMENT FEE SCHEDULE.

Subp. 2a. **Copayment fees to be prorated during start-up service period.** Counties must prorate all copayment fees during the service period when the family first receives service based on the number of calendar days remaining in the service period.

Subp. 2b. **Payment of provider charges that exceed the maximum provider rate.** If the provider's charge for child care is greater than the maximum provider rate allowed under part 3400.0130, the family shall pay, in addition to any family copayment fee, the difference between the maximum provider rate and the provider charge.

Subp. 2c. **Payment of registration and activity fees that exceed the maximum rates.** In addition to the family copayment fee, a family must pay any registration fees that exceed the standards established in part 3400.0130, subpart 7, any optional activity fees, and any activity fees that exceed the standards established in part 3400.0130, subpart 8.

Subp. 5. **Publication of fee schedule in State Register.** The department shall publish annually in the State Register the state median income for a family of three, adjusted for family size, and a fee schedule. This information must be published after the date the state median income is published in the Federal Register by the United States Department of Health and Human Services. The department shall also distribute a copy of the fee schedule and the updated estimate of state median income to each county. The updated fee schedule shall take effect on July 1 or on the first day of the first full quarter following publication of the state median income in the State Register if publication occurs after July 1.

3400.0110 CHILD CARE ASSISTANCE PAYMENTS.

Subpart 1. **Payment options.** Counties must monitor child care payments to ensure that the funds are used for child care.

Subp. 1a. **Date payments must begin.** After approval of an application for child care assistance, payment of child care assistance must be authorized to begin as of the family's date of eligibility as determined under part 3400.0040, subpart 6c.

Subp. 2. **Authorization before payment of legal nonlicensed providers.** After a legal nonlicensed provider is authorized by the county, the county must pay the provider or parent retroactive to the date in item A, B, or C that occurred most recently:

- A. the date on which child care for the family was authorized to begin;
- B. the date the family signed the application for child care; or
- C. the date the family began using the legal nonlicensed provider.

Subp. 2a. **Provisional payment for legal nonlicensed providers.**

A. When a legal nonlicensed provider who has been provisionally authorized under Minnesota Statutes, section 119B.125, subdivision 5, does not receive final authorization by the county, the provisional authorization and payment must be terminated following notice to the provider as required under part 3400.0185 and Minnesota Statutes, section 119B.13, subdivision 5. The county must notify the family using the ineligible provider that the family must choose a new provider to continue receiving child care assistance. A provider's failure to receive final authorization does not cause payments made during the provisional authorization period to be overpayments.

B. If a family appeals the adverse determination of provider eligibility and, while the appeal is pending, continues to use the provider who failed to receive final authorization, payments made after the notice period are subject to recovery as overpayments.

Subp. 3. **County authorization of child care.** Within the limits set by this chapter and Minnesota Statutes, chapter 119B, the amount of child care authorized must reflect the child care needs of the family and minimize out-of-pocket child care costs to the family. The amount of child care authorized must be based on the parents' schedule of participation

in authorized activities, the child's school schedule, the provider's availability, and any other factors that would affect the amount of care that the child needs. The county must pay the provider's full charge up to the applicable maximum rate for all hours of child care authorized and scheduled for the family. When more than 50 hours of child care assistance for one child are authorized with one provider in a week, the county may reimburse the provider in an amount that exceeds the applicable maximum weekly rate, if the provider charges the same amount for more than 50 hours of care for a family not receiving child care assistance. A county must not authorize or pay for more than 120 hours of child care assistance per child every two weeks. To convert child care paid on a full-day or weekly basis into hours to determine if payment exceeds 120 hours of child care assistance, counties must follow the standards in items A and B.

A. A full-day is equal to ten hours of child care.

B. A week is equal to 50 hours of child care.

Subp. 4a. **Reimbursement from other sources for child care costs.** A county must reduce the amount of a family's child care assistance payment by the amount of reimbursement earmarked for the same child care expenses that the family receives from sources other than the child care assistance fund.

Subp. 7. **County payment policies and schedule.** A county may not require parents to pay providers in advance of receiving payments from the child care fund as a condition for receiving payments from the child care fund. The county shall make payments at least monthly. Providers must be sent the forms necessary to bill for payment on or before the beginning of the billing cycle if the county has received the information necessary for child care to be authorized before this date.

Subp. 8. **Sick child care.** Sick child care means child care services provided to children who as a result of illness cannot attend the family's regular provider. In addition to making payments for regular child care, the county may make payments for sick child care. If the county chooses to pay sick child care, payment for sick child care must be at a rate comparable to like care arrangements in the county. The county's sick child care policy and rate shall be included in the county's child care fund plan required under part 3400.0150.

Subp. 9. **Payment during child absences and holidays.**

A. If a provider does not charge all families for days on which a child is absent from care, the child care assistance program must not pay that provider for days on which a child is absent from care.

B. If a provider charges all families for days on which a child is absent from care, the child care assistance program must pay that provider for child absent days according to Minnesota Statutes, section 119B.13, subdivision 7.

C. Provider charges for absent days in excess of the amount established by Minnesota Statutes, section 119B.13, subdivision 7, are the responsibility of the family receiving child care assistance.

D. A provider must be paid for holiday days according to Minnesota Statutes, section 119B.13, subdivision 7, paragraph (b). State or federal holidays are determined according to Minnesota Statutes, section 645.44, subdivision 5. A provider can be paid for a holiday day only if the provider meets the requirements in Minnesota Statutes, section 119B.13, subdivision 7, paragraph (b), the provider does not provide care on the holiday, and it is in the provider's policies to charge all families for the holiday. If care is available on the holiday, but the child is absent on that day, the day is an absent day. If a provider is closed on a cultural or religious holiday not identified in Minnesota Statutes, section 645.44, subdivision 5, a parent may substitute that holiday for one of the ten state and federal holidays identified in Minnesota Statutes, section 645.44, subdivision 5, if the parent gives notice of the substitution to the county before the holiday occurs or within ten days after the holiday.

E. The absent day provisions in this subpart and in Minnesota Statutes, section 119B.13, subdivision 7, including the limits on paid absent days and holidays, apply to child care assistance payments for child care provided during notice periods.

Subp. 10. **Payment during medical leaves of absence.** Counties must grant child care assistance during a parent's medical leave of absence from education or employment if:

A. the parent is incapable of providing child care during the medical leave or absence;

B. the parent is expected to return to employment or an approved education or training program within 90 calendar days after leaving the job, education, or training program; and

C. the necessity of the medical leave and the inability to provide child care are documented by a physician or licensed psychologist.

The amount of child care authorized during the medical leave of absence must not exceed the equivalent of one month of full-time child care.

Subp. 11. **Payment during notice periods.** Child care assistance payments for child care provided during notice periods are subject to all payment rules and limits identified under this part.

3400.0120 ELIGIBLE PROVIDERS AND PROVIDER REQUIREMENTS.

Subpart 1. **Eligible providers.** Providers who meet the definition of provider in Minnesota Statutes, section 119B.011, subdivision 19, are eligible for payment from the child care fund. Within the limitations specified in Minnesota Statutes, sections 119B.09, subdivision 5, and 119B.25, parents may choose child care providers that best meet the needs of their family. Parents may choose more than one provider. A county may not deny a parent eligible for child care assistance the use of a provider holding a valid child care license.

Subp. 1a. **Provider acknowledgment.** A provider must sign a provider acknowledgment and the county must have a signed provider acknowledgment before the provider or parent may receive payment under the child care fund. The provider acknowledgment must include the following information:

A. the provider's rate, charges for child absences and holidays, any notice days required before a child discontinues care, and any required registration or activity fees;

B. documentation of the provider's license status and, if the provider is seeking the provider accreditation rate bonus, any accreditation or credential held by the provider;

C. a statement acknowledging that charging child care assistance participants more than families not receiving child care assistance for like services or wrongfully obtaining child care assistance may be a crime;

D. a statement acknowledging that parents must be given unlimited access to their children and to the provider caring for the children during all hours that the children are in the provider's care;

E. a statement acknowledging that the provider is responsible for notifying the county as provided in subpart 5 of child absence days and the end of care;

F. a statement acknowledging that the provider is responsible for immediately notifying the county of any changes to the information supplied by the provider in the provider's acknowledgment;

G. a statement acknowledging that the provider is a mandated reporter of maltreatment of minors under Minnesota Statutes, section 626.556; and

H. a statement acknowledging that when the county knows that a particular provider or child care arrangement is unsafe, the county may deny child care assistance payments to that provider.

Subp. 2. Authorization of legal nonlicensed providers.

A. A legal nonlicensed provider must be authorized by the county before the provider or parent may receive a payment under the child care fund. To be authorized by the county, a provider must provide the county with the following information:

- (1) the provider's name, age, and address;
- (2) the provider acknowledgment required by subpart 1a;
- (3) an assurance that the provider is eligible to provide unlicensed care under Minnesota Statutes, section 245A.03, subdivision 2, paragraph (a);
- (4) a release to permit information on substantiated parental complaints concerning the health and safety of children in the provider's care to be disclosed to the public according to Minnesota Statutes, chapter 13;
- (5) an assurance that the provider is in compliance with state and local health ordinances and building and fire codes applicable to the premises where child care is provided; and
- (6) an acknowledgment that the parent and the legal nonlicensed provider have reviewed the health and safety information provided by the county.

B. Legal nonlicensed providers who will receive payment from the county must provide the county with the provider's Social Security or tax identification number. The county may ask legal nonlicensed providers who will not receive payment from the county for their Social Security numbers; but legal nonlicensed providers who will not receive payment from the county are not required to disclose this information. Before asking for a legal nonlicensed provider's Social Security number, the county must tell the legal nonlicensed provider whether that disclosure is mandatory or voluntary, by what statutory or other authority the number is solicited, and how the number will be used.

C. Legal nonlicensed family child care providers also must provide the county with an assurance that the provider will obtain an immunization record for each child in the provider's care within 90 days of starting to care for the child.

Subp. 2a. Release for in-home providers. To be authorized, an in-home provider must sign a release allowing the parent employing that provider to see information on the remittance advice about the amount of any funds being withheld from the payment for the provider and the reason for those withholdings.

Subp. 3. Parental access to children in care. Providers must permit parents unlimited access to their children and to the provider caring for their children during all hours the children are in the care of the provider.

Subp. 5. Notice to county required when care has terminated. When a provider knows that a family has ended care with the provider, the provider must notify the county that care has been terminated. When a provider believes that a family will be ending care with the provider, the provider must immediately notify the county of the date on which the provider believes the family will end care. A provider must also notify the county if a child or children have been absent for more than seven consecutive scheduled days.

3400.0130 CHILD CARE PROVIDER RATES.

Subpart 1. Rate determination. The commissioner shall determine the applicable maximum rate as described in Minnesota Statutes, section 119B.13. Any rate survey conducted by the commissioner shall include a survey of registration fees when it is usual and customary for a category of provider to charge registration fees.

Subp. 1a. **Maximum county child care assistance rate.** Except as provided in this part, the maximum rate that a county may pay for child care assistance is the provider's rate or the applicable maximum rate determined by the commissioner under Minnesota Statutes, section 119B.13, whichever is less. Except as provided in this part, if the provider's rate is more than the applicable maximum rate, the county may not pay more than the difference between the applicable maximum rate and the family's copayment fee.

Subp. 2. **Rate determination for license-exempt centers.** Rates paid to license-exempt centers as defined in Minnesota Statutes, section 245A.03, subdivision 2, must be the applicable maximum rate for licensed child care centers or the provider rate, whichever is less.

Subp. 3. **Rate determination; children with special needs.** A county must submit a request to pay a special needs rate to the commissioner. The request must be submitted with or as an amendment to the county child care fund plan. Upon written approval by the commissioner, the approved special needs rate must be paid retroactive to the date of the provider or parent request for the special needs rate.

Subp. 3a. **Rate determination; children with special needs due to disability.** When a parent or a provider asks the county for a special needs rate for an individual child with disabilities that exceeds the applicable maximum rate, the county must use the following process to determine whether a special needs rate is necessary and, if so, to establish the requested special needs rate. The county must:

- A. obtain documentary evidence of the child's disability;
- B. obtain the following documentation from the child care provider:
 - (1) a description of the specialized training, services, or environmental adaptations that the provider will furnish to meet the individual needs of the child;
 - (2) the provider's assurance of compliance with applicable provisions of the Americans with Disabilities Act;
 - (3) the provider's assurance that the rate being sought is the same as the rate that would be charged for similar services provided to a child with a disability in a family not receiving child care assistance; and
 - (4) if applicable, a statement from the provider explaining that the rate the provider charges for all children in care should be adopted as the special needs rate for the child with disabilities because the provider has chosen to spread the cost of caring for children with special needs across all families in care; and
- C. seek the commissioner's approval of the special needs rate as provided in subpart 3.

Subp. 3b. **Rate determination; children with special needs due to inclusion in at-risk population.** To determine a special needs rate for a child who is included in an at-risk population defined in the county's child care fund plan, the county must use the following procedures. The county must:

- A. obtain documentary evidence showing that the child is included in the at-risk population defined in the county's child care fund plan;
- B. obtain the following documentation from the child care provider:
 - (1) a description of the specialized training, services, or environmental adaptations that the provider will furnish to meet the individual needs of the child or the at-risk population;
 - (2) the provider's assurance that the rate being sought is the same as the rate that would be charged for similar services provided to a child in the at-risk population in a family not receiving child care assistance; and

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(3) if applicable, a statement from the provider explaining that the rate the provider charges for all children in care should be adopted as the special needs rate for the child in the at-risk population because the provider has chosen to spread the cost of caring for children with special needs across all families in care;

C. determine how many providers in the county offer child care for children in the at-risk population;

D. identify the 75th percentile rate if the county finds that four or more providers offer child care for children in the at-risk population and pay the 75th percentile rate, the rate negotiated with the provider by the county, or the provider's rate, whichever is less;

E. pay the lesser of the rate negotiated with the provider by the county or the provider's rate if the county finds that fewer than four providers offer child care for children in the at-risk population; and

F. seek the commissioner's approval of the special rate as provided in subpart 3.

Subp. 5. **Child care rate.** Child care payments shall be based on the applicable maximum rates in the county where care is provided when the care is provided in Minnesota. When child care is provided outside the state of Minnesota, the maximum rate must be based on the applicable maximum rate in the participant's county of residence. If a child remains in an age-based child care setting beyond the age at which the licensing laws would allow that child to move to a different age-based child care setting and (1) the child's age is within the range allowed by the licensing laws for that age-based child care setting, or (2) the child is in that age-based child care setting due to a licensing variance, the maximum rate paid for that child's care must be the rate for the age-based child care setting in which the child is located. A child is considered to be in the school-age rate category on the September 1 following the child's fifth birthday unless the parent informs the county that the child will not be starting school. All changes to provider rates shall be implemented on the Monday following the effective date of the rate change.

Subp. 5a. **Rates for in-home care.** When care is provided in the child's home, the applicable maximum rate must be based on the allowable rate for legal nonlicensed family child care.

Subp. 7. **Payment of registration fees.** If a provider charges families a registration fee to enroll children in the program and the registration fee is not included in the provider rate, the county shall pay the provider registration fee or the 75th percentile of the registration fees surveyed in subpart 1, whichever is less. The county may not pay for more than two registrations per child in a 12-month period.

3400.0140 COUNTY RESPONSIBILITIES.

Subpart 1. **County child care assistance policies and procedures.** Counties shall adopt policies and procedures for providing child care assistance to enable eligible applicants to seek or retain employment or to participate in education or training programs. All county policies that apply to child care assistance must be in writing and must be included in the county's biennial child care fund plan required under part 3400.0150.

Subp. 2. **Child care assistance information.** The county shall provide information on child care assistance to child care service providers, social service agencies, and the local news media as it deems necessary to ensure the full use of its child care fund allocation.

Subp. 4. **Determination of providers eligible for payments.** The county's process for approving providers eligible for payments under the child care fund may not exceed 30 calendar days, or 45 calendar days with the approval of the applicant, from the date the child care application is approved, the date the child care provider is selected by the applicant, or, the date the county received the results of the background investigation required by Minnesota Statutes, section 119B.125, subdivision 2, whichever is later. Reimbursement for child care expenses must be made according to the date of eligibility established in part 3400.0040, subpart 6c. If the county determines that a provider chosen by an applicant is

not eligible to receive child care payments under the child care fund, the applicant may appeal the county's determination under part 3400.0230.

Subp. 5. **Additional information for legal nonlicensed providers.** The county shall provide each authorized legal nonlicensed family child care provider health and safety material supplied by the department and shall refer the provider to the child care resources and referral agency. The county must tell the provider that the county is required to keep a record of substantiated parental complaints concerning the health and safety of children in the care of legal nonlicensed providers and that, upon request, information governing substantiated complaints shall be released to the public as authorized under Minnesota Statutes, chapter 13.

Subp. 6. **Duties upon receipt of complaints against legal nonlicensed providers.** Within 24 hours of receiving a complaint concerning the health or safety of children under the care of a legal nonlicensed provider, a county must relay the complaint to:

A. the county's child protection agency if the complaint alleges child maltreatment as defined in Minnesota Statutes, section 626.556, subdivision 10e;

B. the county's public health agency if the complaint alleges a danger to public health due to communicable disease, unsafe water supply, sewage or waste disposal, or building structures;

C. local law enforcement if the complaint alleges criminal activity that may endanger the health or safety of children under care; or

D. other agencies with jurisdiction to investigate complaints relating to the health and safety of a child.

If a complaint is substantiated under item A, the county must keep a record of the substantiated complaint as provided in Minnesota Statutes, section 626.556. If a complaint is substantiated under items B to D, the county must keep a record of the substantiated complaint for three years. Upon request, information governing substantiated complaints shall be released to the public as authorized under Minnesota Statutes, chapter 13. Upon receiving notice of a substantiated complaint under items A to D, the county shall not make subsequent payments to that provider from the child care fund for child care services provided by that provider unless the conditions underlying the substantiated complaint have been corrected.

Subp. 7. **County contracts and designation of administering agency.** Counties may contract for the administration of all or part of the child care fund. The county shall designate the agency authorized to administer the child care fund in the county's child care fund plan. The county must describe in its child care fund plan how it will oversee the contractor's performance.

Subp. 8. **Agreement with employment and training services providers.** Cooperative agreements with employment and training services providers must specify that MFIP families participating in employment services and meeting the requirements of part 3400.0080 are eligible for child care assistance from the county responsible for the MFIP participant's approved job search support or employment plan or according to Minnesota Statutes, section 256G.07.

Subp. 9. **Local match.** The county shall provide a local match according to Minnesota Statutes, section 119B.11, subdivision 1.

Subp. 9a. **Child care assistance funding.** In the manner prescribed by the commissioner, counties shall claim funding for child care expenditures for all eligible recipients who are in employment, education, training, or other preemployment activities allowed under the federal and state reimbursement programs. The commissioner shall allocate any federal or state earnings to the county that claimed the funding and the county shall use the earnings to expand funding for child care services.

Subp. 10. **Eligibility priorities for beginning assistance.** If a county's basic sliding fee program allocation for child care is insufficient to fund all applications for child care assistance, the county may prioritize eligibility among the groups that remain to be served after the county has complied with the priority requirements set forth in Minnesota Statutes, section 119B.03, subdivision 4. The county shall include its rationale for the prioritization of eligibility for beginning assistance in its biennial child care fund plan. To the extent of available allocations, no eligible family may be excluded from receiving child care assistance.

Subp. 14. **Child care fund reports.** Counties must submit financial and program activity reports according to instructions and schedules that the commissioner establishes after considering such factors as the department's need to receive county data in a manner and on a schedule that meets federal reporting deadlines and the counties' need for lead time when changes in reporting requirements occur.

3400.0150 CHILD CARE FUND PLAN.

Subpart 1. **Submittal of plan.** By the date established by the commissioner, the county shall submit to the commissioner a biennial child care fund plan. The commissioner may require updates of information in the plan as necessary to comply with this chapter, Minnesota Statutes, sections 119B.011 to 119B.16, and federal law.

Subp. 2. **Plan content.** The plan must contain a complete description of the county's child care assistance program for applicants and participants eligible for assistance under Minnesota Statutes, chapter 119B. The plan must include the information required by Minnesota Statutes, section 119B.08, subdivision 3; the information required by this chapter; and all written forms, policies, and procedures used to administer the child care funds. The plan must describe how it serves persons with limited English proficiency, as required by title VI of the Civil Rights Act of 1964, United States Code, title 42, sections 2000, et seq. The information in the plan must be in the form prescribed by the commissioner and must include a description of the process used to assure that the information, forms, and notices about child care assistance are accurate, clearly written, and understandable to the intended recipient.

Subp. 3. **Plan amendments.** A county may amend its child care fund plan at any time but the amendment must be approved by the commissioner before it becomes effective. If approved by the commissioner, the amendment is effective on the date requested by the county unless a different effective date is set by the commissioner. Plan amendments must be approved or disapproved by the commissioner within 60 days after receipt of the amendment request.

3400.0170 INCOME ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Subpart 1. **Proof of income eligibility.** An applicant requesting child care assistance must provide proof of income eligibility. For the purpose of determining income eligibility, annual income is the income of the family for the current month multiplied by 12, the income for the 12-month period immediately preceding the date of application, or the income calculated by the method that provides the most accurate assessment of annual income available to the family. The administering agency must use the method that provides the most accurate assessment of annual income currently available to the family. Income must be verified with documentary evidence. If the applicant does not have sufficient evidence of income, the administering agency must offer the applicant the opportunity to sign an informational release to permit the administering agency to verify whether the applicant qualifies for child care assistance.

Subp. 3. **Evaluation of income.** The administering agency shall determine income received or available to a family according to subparts 4 to 11. All income, unless specifically excluded in subpart 6, must be counted as income.

Subp. 4. **Determination of annual income.** The income standard for determining eligibility for child care assistance is annual income. Annual income is the sum of earned

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income, self-employment income, unearned income, and lump sum payments, which must be treated according to subpart 13. Negative self-employment income must be included in the determination of annual income, resulting in a reduction in total annual income. Earned income, self-employment income, unearned income, and lump sum payments must be calculated separately.

Subp. 6a. **Deductions from income.** The following items must be deducted from annual income:

- A. child or spousal support paid to or on behalf of a person or persons who live outside of the household; and
- B. funds used to pay for health and dental insurance premiums for family members.

Subp. 7. **Earned income from self-employment.** In determining annual income for purposes of eligibility under this part, the administering agency shall determine earned income from self-employment. Earned income from self-employment is the difference between gross receipts and authorized self-employment expenses which may not include expenses under subpart 8. Self-employment business records must be kept separate from the family's personal records. If the person's business is a partnership or a corporation and that person is drawing a salary, the salary shall be treated as earned income under subpart 5.

Subp. 8. **Self-employment deductions which are not allowed.** In determining eligibility under this part, self-employment expenses must be subtracted from gross receipts. For purposes of this subpart, the document in items I to K is incorporated by reference. It is available through the Minitex interlibrary loan system. It is subject to frequent change. If the document in items I to K is amended, and if the amendments are incorporated by reference or otherwise made a part of state or federal law applicable to self-employment deductions, then the amendments to the document are also incorporated by reference into this subpart. However, the expenses listed in items A to P shall not be subtracted from gross receipts:

- A. purchases of capital assets;
- B. payments on the principal of loans for capital assets;
- C. depreciation;
- D. amortization;
- E. the costs of building an inventory, until the time of sale;
- F. transportation costs that exceed the amount allowed for use of a personal car in the United States Internal Revenue Code;
- G. the cost of transportation between the individual's home and his or her place of employment;
- H. wages and salaries paid to and other employment deductions made for members of a family for whom an employer is legally responsible, provided family income is only counted once;
- I. monthly expenses for each roomer greater than the flat rate deduction listed in the current Combined Program Manual issued by the Department of Human Services;
- J. monthly expenses for each boarder greater than the flat rate deduction listed in the current Combined Program Manual issued by the Department of Human Services;
- K. monthly expenses for each roomer-boarder greater than the flat rate deduction listed in the current Combined Program Manual issued by the Department of Human Services;
- L. annual expenses greater than two percent of the estimated market value on a county tax assessment form as a deduction for upkeep and repair against rental income;

M. expenses not allowed by the United States Internal Revenue Code for self-employment income, unless specifically authorized in this chapter;

N. federal, state, and local income taxes;

O. employer's own share of FICA; and

P. money set aside for the self-employed person's own retirement.

Subp. 9. **Self-employment budget period.** Gross receipts from self-employment must be budgeted in the month in which they are received. Expenses must be budgeted against gross receipts in the month the expenses are paid except for items A to C.

A. The purchase cost of inventory items, including materials that are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

B. Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker's compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs that are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross receipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

C. Gross receipts from self-employment may be prorated forward to equal the period of time over which the expenses were incurred. However, gross receipts must not be prorated over a period that exceeds 12 months. This provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

Subp. 10. **Determination of farm income.** Farm income must be determined for a one-year period. Farm income is gross receipts minus operating expenses, except for expenses listed in subpart 8. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from the sale of home-produced foods.

Subp. 11. **Determination of rental income.**

A. Income from rental property is considered self-employment earnings when the owner spends an average of 20 or more hours per week on maintenance or management of the property. The administering agency shall deduct an amount for upkeep and repairs according to subpart 8, item L, for real estate taxes, insurance, utilities, and interest on principal payments.

B. When a family lives on the rental property, the administering agency shall divide the expenses for upkeep, taxes, insurance, utilities, and interest by the number of units to determine the expense per unit. The administering agency shall deduct expenses from rental income only for the number of units rented, not for units occupied by family members.

C. When an owner does not spend an average of 20 or more hours per week on maintenance or management of the property, income from rental property is considered unearned income.

D. The deductions described in this subpart are subtracted from gross rental receipts.

3400.0180 REDETERMINATION OF ELIGIBILITY.

A. The county must redetermine each participating family's eligibility at least every six months. The county must redetermine the eligibility of families in the start-up phase of self-employment without an approved employment plan more frequently than once every six months if existing documentation is insufficient to accurately predict self-employment income. If a family reports a change in an eligibility factor before the

family's next regularly scheduled redetermination, the county must recalculate eligibility without requiring verification of any eligibility factor that did not change.

B. The county must not treat a redetermination of eligibility as a new application for child care assistance. The participant is responsible for providing documentary evidence of continued eligibility.

C. If redetermination establishes that a family is ineligible for further child care assistance, the county shall terminate the child care assistance as provided in part 3400.0185. If redetermination establishes the need for a change in the family's copayment, revisions shall be calculated according to part 3400.0100. When a change in income affects the amount of a participant's copayment, the new copayment amount is effective on the first day of the service period following the 15-day notice period.

D. If a family timely reports the information required by part 3400.0040, subpart 4, and redetermination establishes a need for a change in the amount of the family's child care assistance, the amount of child care assistance paid to the family between the date the change was reported and the first date that the new child care assistance payment would be effective if the county properly implemented the change does not constitute an overpayment.

3400.0183 TERMINATION OF CHILD CARE ASSISTANCE.

Subpart 1. Conditions for termination of child care assistance.

A. A county may terminate child care assistance for families already receiving assistance when the county receives: (1) a revised allocation from the child care fund that is smaller than the allocation stated in the notice sent to the county under part 3400.0030; and (2) such short notice of a change in its allocation that the county could not have absorbed the difference in the allocation. The county must consult with and obtain approval from the commissioner before terminating assistance under this subpart.

B. If the conditions described in this subpart occur, the county may terminate assistance to families in the order of last on, first off. When funds become available, counties must reinstate families that remain eligible for child care assistance and whose child care assistance was terminated due to insufficient funds before the county accepts new applications. Those families whose child care assistance was most recently terminated due to insufficient funds shall be reinstated first.

Subp. 2. Conditions under which termination of child care assistance is required. A county must terminate a family's child care assistance under the following conditions:

A. when the family asks the county to do so;

B. when the family is no longer eligible to receive child care assistance under this chapter and Minnesota Statutes, chapter 119B; or

C. when a member of the family has been disqualified from the child care assistance program.

Subp. 5. Effective date of disqualification period. The effective date of a disqualification period is the later of:

A. the date the family member was found guilty of wrongfully obtaining or attempting to obtain child care assistance by federal court, state court, or an administrative hearing determination or waiver, through a disqualification consent agreement, as part of an approved diversion plan under Minnesota Statutes, section 401.065, or as part of a court-ordered stay with probationary or other conditions; or

B. the effective date of the child care assistance program termination notice.

3400.0185 TERMINATION AND ADVERSE ACTIONS; NOTICE REQUIRED.

Subpart 1. Notice of termination of child care assistance to participants.

A. The county must notify a participant in writing of the termination of child care assistance. The notice must include the following information:

- (1) the date the termination is effective;
- (2) the reason or reasons why assistance is being terminated;
- (3) the statute, rule, or county child care fund plan provision that supports termination of assistance;
- (4) the participant's right to appeal the termination and the procedure for doing so; and
- (5) when the participant appeals the proposed action before the effective date of termination, the participant may choose:
 - (a) to receive benefits while the appeal is pending, subject to recovery if the termination is upheld; or
 - (b) to not receive benefits while the appeal is pending and to receive reimbursement for documented eligible child care expenditures made or incurred pending appeal if the termination is reversed.

B. If child care assistance under part 3400.0060 is being terminated because a participant has moved to another county, the notice also must state that to continue receiving child care assistance under part 3400.0060 from the new county, the participant must apply for child care assistance in the new county within 60 days of the move.

C. The notice must be mailed to the participant's last known address at least 15 calendar days before terminating assistance.

D. If the participant's child care assistance is terminated under part 3400.0183, subpart 2, item A, and, before the effective date of termination, the participant asks the county to continue child care assistance, the termination must not take effect. If the participant's child care assistance is terminated under part 3400.0183, subpart 2, item B, and, before the effective date of termination, the participant reestablishes eligibility for child care assistance, the termination must not take effect.

Subp. 2. Notice of termination of child care assistance to providers.

A. When a family's child care assistance is terminated, the county must send the family's child care provider a notice containing only the following information:

- (1) the family's name;
- (2) that child care assistance for the family has been terminated;
- (3) the effective date of the termination; and
- (4) that child care payments will no longer be made effective on the date of termination, unless the family asks to continue receiving assistance pending an appeal. The notice to a provider must not contain information on why payments will no longer be made.

B. When a family stops using a provider but continues to receive assistance, the county must send the provider a notice containing the following information:

- (1) the family's name;
- (2) that the family has decided to stop using that provider;
- (3) the effective date that child care assistance payments will end; and
- (4) that child care payments will no longer be made effective on the date of termination.

C. This item applies to participants using a provider licensed by the state of Minnesota. Except in cases where the provider's license has been temporarily immediately suspended under Minnesota Statutes, section 245A.07, the county must mail the notice to the participant at least 15 calendar days before terminating payment to the provider. When the provider's license has been temporarily immediately suspended under Minnesota Statutes, section 245A.07, the county must send a notice of termination to the provider that is effective on the date of the temporary immediate suspension.

D. This item applies to participants using a legal nonlicensed provider, license exempt center, or provider licensed by an entity other than the state of Minnesota. Except in cases where there is an imminent risk of harm to the health, safety, or rights of a child in care, the county must mail the notice to the provider at least 15 calendar days before terminating payment to the provider. In cases where there is an imminent risk of harm to the health, safety, or rights of a child in care, the county must send a notice of termination that is effective on the date of the notice. Whether there is an imminent risk of harm is determined by the county that authorized the provider for the family.

Subp. 3. Notice to participants of adverse actions.

A. The county must give a participant written notice of any action adversely affecting the participant.

B. The notice must include the following information:

- (1) a description of the adverse action;
- (2) the effective date of the adverse action;
- (3) the reason or reasons why the adverse action is being taken;
- (4) the statute, rule, or county child care fund plan provision that supports the adverse action;
- (5) that the participant has the right to appeal the adverse action and the procedure for doing so; and
- (6) that if the participant appeals the adverse action before the effective date of the action, the participant may choose:
 - (a) to continue receiving the same level of benefits while the appeal is pending, subject to recoupment or recovery if the adverse action is upheld; or
 - (b) to receive the level of benefits indicated by the adverse action while the appeal is pending and to receive reimbursement for documented eligible child care expenditures made or incurred pending appeal if the adverse action is reversed.

C. The notice must be mailed to the participant's last known address at least 15 calendar days before the effective date of the adverse action.

D. If the participant corrects the condition requiring an adverse action before the effective date of the adverse action, the adverse action must not take effect.

Subp. 4. Notice to providers of actions adverse to families. The county must give a provider written notice of the following actions adverse to families: a reduction in the hours of authorized care and an increase in the family's copayment. The notice must include only the following information:

- A. the family's name;
- B. a description of the adverse action that does not contain any information about why the action was taken;
- C. the effective date of the adverse action; and

D. a statement that unless the family appeals the adverse action before the effective date, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

Subp. 5. **Notice to providers of actions adverse to the provider.** The county must give a provider written notice of the following actions adverse to the provider: a denial of authorization, a termination of authorization, a reduction in the number of hours of care with that provider, and a determination that the provider has an overpayment. The notice must include the following information:

A. a description of the adverse action;

B. the effective date of the adverse action; and

C. a statement that unless a family appeals the adverse action before the effective date or the provider appeals the overpayment determination, the adverse action will occur on the effective date. The notice must be mailed to the provider at least 15 calendar days before the effective date of the adverse action.

3400.0187 RECOUPMENT AND RECOVERY OF OVERPAYMENTS.

Subpart 1. **State recovery of overpayments.** The commissioner must recover from counties any state or federal money that was spent for persons found to be ineligible for child care assistance, except as provided in Minnesota Statutes, section 119B.11, subdivision 3.

Subp. 2. **Notice of overpayment.** The county must notify the person or persons assigned responsibility for the overpayment of the overpayment in writing. A notice of overpayment must specify the reason for the overpayment, the time period in which the overpayment occurred, the amount of the overpayment, and the right to appeal the county's overpayment determination.

Subp. 3. **Redetermination of eligibility.** When a county discovers that a family has received an overpayment, the county must immediately redetermine the family's eligibility for child care assistance.

Subp. 4. **Recoupment of overpayments from participants.** If the redetermination of eligibility indicates the family remains eligible for child care assistance, the county must recoup the overpayment by reducing the amount of assistance paid to or on behalf of the family for every service period at the rates in item A, B, C, or D until the overpayment debt is retired.

A. When a family has an overpayment due to agency or provider error, the recoupment amount is one-fourth the family's copayment or \$10, whichever is greater.

B. When the family has an overpayment due to the family's first failure to report changes as required by part 3400.0040, subpart 4, the recoupment amount is one-half the family's copayment or \$10, whichever is greater.

C. When a family has an overpayment due to the family's failure to provide accurate information at the time of application or redetermination or the family's second or subsequent failure to report changes as required by part 3400.0040, subpart 4, the recoupment amount is one-half the family's copayment or \$50, whichever is greater.

D. When a family has an overpayment due to a violation of Minnesota Statutes, section 256.98, subdivision 1, as established by a court conviction, a court-ordered stay of conviction with probationary or other terms, a disqualification agreement, a pretrial diversion, or an administrative disqualification hearing or waiver, the recoupment amount equals the greater of:

(1) the family's copayment;

(2) ten percent of the overpayment; or

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(3) \$100.

E. This item applies to families who have been disqualified or found to be ineligible for the child care assistance program and who have outstanding overpayments. If a disqualified or previously ineligible family returns to the child care assistance program, the county must begin recouping the family's outstanding overpayment using the recoupment schedule in items A to D unless another repayment schedule has been specified in a court order.

F. If a family has more than one overpayment, the overpayments must not be consolidated into one overpayment. Instead, each overpayment must be recouped according to the schedule specified in this subpart from the child care benefit paid for the service period. If the amount to be recouped in a service period exceeds the child care benefit paid for that service period, the amount recouped must be applied to overpayments in the following order:

(1) payment must first be applied to the oldest overpayment being recouped under item D and then to any other overpayments to be recouped under this item according to the age of the claim;

(2) payment then must be applied to the oldest overpayment being recouped under item C and then to any other overpayments to be recouped under this item according to the age of the claim;

(3) payment then must be applied to the oldest overpayment being recouped under item B and then to any other overpayments to be recouped under this item according to the age of the claim; and

(4) payment then must be applied to the oldest overpayment being recouped under item A and then to any other overpayments to be recouped under this item according to the age of the claim.

Subp. 6. **Recoupment of overpayments from providers.** If the provider continues to receive child care assistance payments, the county must recoup the overpayment by reducing the amount of assistance paid to the provider for every payment at the rates in item A, B, or C until the overpayment debt is retired.

A. When a provider has an overpayment due to agency or family error, the recoupment amount is one-tenth the provider's payment or \$20, whichever is greater.

B. When a provider has an overpayment due to the provider's failure to provide accurate information, the recoupment amount is one-fourth the provider's payment or \$50, whichever is greater.

C. When a provider has an overpayment due to a violation of Minnesota Statutes, section 256.98, subdivision 1, as established by a court conviction, a court-ordered stay of conviction with probationary or other terms, a disqualification agreement, a pretrial diversion, or an administrative disqualification hearing or waiver, the recoupment amount equals the greater of:

(1) one-half the provider's payment;

(2) ten percent of the overpayment; or

(3) \$100.

D. This item applies to providers who have been disqualified from or are no longer able to be authorized by the child care assistance program and who have outstanding overpayments. If a provider returns to the child care assistance program as a provider or a participant, the county must begin recouping the provider's outstanding overpayment using the recoupment schedule in items A to D unless another repayment schedule has been specified in a court order.

E. If a provider has more than one overpayment, the overpayments must not be consolidated into one overpayment. Instead, each overpayment must be recouped according to the schedule specified in this subpart from the payment made to the provider for the service period. If the amount to be recouped in a service period exceeds the payment to the provider for that service period, the amount recouped must be applied to overpayments in the following order:

(1) payment must first be applied to the oldest overpayment being recouped under item C and then to any other overpayments to be recouped under this item according to the age of the claim;

(2) payment then must be applied to the oldest overpayment being recouped under item B and then to any other overpayments to be recouped under this item according to the age of the claim; and

(3) payment then must be applied to the oldest overpayment being recouped under item A and then to any other overpayments to be recouped under this item according to the age of the claim.

3400.0200 PAYMENTS TO COUNTIES OF ADMINISTRATIVE FUNDS.

The commissioner shall make administrative funds payments to the counties on a monthly basis. The commissioner may certify an advance to the counties for the first quarter of the fiscal year or the first quarter of the allocation period. Subsequent payments made to the counties for administrative expenses shall be based on actual expenditures as reported by the counties in the financial and program activity report required under part 3400.0140, subpart 14.

3400.0220 AUDIT EXCEPTIONS.

The commissioner shall recover from counties state or federal money spent for child care that is ineligible under this chapter. If a federal audit exception is taken based on a percentage of federal earnings, all counties shall pay a share proportional to their respective federal earnings during the period in question.

3400.0230 RIGHT TO FAIR HEARING.

Subp. 3. Child care payments when fair hearing is requested.

A. If the applicant or participant requests a fair hearing before the effective date of termination or adverse action or within ten days after the date of mailing the notice, whichever is later, the termination or adverse action shall not be taken until the conclusion of the fair hearing. Child care assistance paid pending a fair hearing is subject to recovery under part 3400.0187 to the extent the commissioner finds on appeal that the participant was not eligible for the amount of child care assistance paid.

B. If the commissioner finds on appeal that child care assistance should have been terminated or the amount of benefits reduced, the county must send a notice of termination or reduction in benefits effective the date of the notice to the family and the child care provider.

C. A participant may appeal the termination of child care assistance and choose not to receive child care assistance pending the appeal. If the commissioner finds on appeal that child care assistance should not have been terminated, the county must reimburse the participant for documented eligible child care expenditures made or incurred pending the appeal.

3400.0235 AT-HOME INFANT CHILD CARE PROGRAM.

Subpart 1. **Purpose and applicability.** This part governs the administration of the at-home infant child care program. All provisions in parts 3400.0010 to 3400.0230 apply

to the at-home infant child care program unless otherwise specified in this part or in Minnesota Statutes, section 119B.035.

Subp. 2. **Administration of at-home infant child care program.** Within the limits of available funding the commissioner shall make payments for expenditures under the at-home infant child care program. Participation in the statewide pool shall be determined based on the order in which requests are received from counties. Following the birth or arrival of an infant, counties shall submit family requests for participation in the at-home infant child care program on forms provided by the commissioner. The commissioner shall respond within seven days to county inquiries about the availability of funds. The commissioner shall monitor the use of the pool and if the available funding is obligated, the commissioner shall create a waiting list of at-home infant child care referrals from the counties. As funds become available to the pool, the commissioner shall notify counties in which eligible families on the waiting list reside.

Subp. 3. **General eligibility requirements.** Items A to E govern eligibility for the at-home infant child care program.

A. A family is eligible to receive assistance under the at-home infant child care program if one parent provides full-time care for the infant. The eligible parent must meet the requirements of Minnesota Statutes, section 119B.035, subdivision 3. The requirements of caring for the infant full-time may be met by one or both parents. For purposes of this part, eligible parents include birth parents, adoptive parents, and stepparents. Nonfamily members may provide regular care for the child but are limited to a maximum of ten hours of care per week.

B. A family may apply for the at-home infant child care program before the child is born or anytime during the infant's first year. The family must apply before the end of the infant's first year to receive an at-home infant child care subsidy. Following the birth of a child, a family is eligible to receive a subsidy under the at-home infant child care program according to the date of eligibility in Minnesota Statutes, section 119B.09, subdivision 7, and when funding is available. A family shall only receive subsidy payments through the infant's twelfth month. "Infant" means a child from birth through 12 months of age and includes adopted infants.

C. A family is limited to a lifetime total of 12 months of at-home infant child care assistance. At the time of application to the program, the parent or parents must declare whether they have previously participated in the at-home infant child care program. If the parent or parents declare that they have participated in the at-home infant child care program, the commissioner shall, at the request of the county, inform the county of the remaining months of eligibility for the at-home infant child care program.

D. At the time of application to the at-home infant child care program, the family must meet the eligibility requirements in Minnesota Statutes, section 119B.035, subdivision 2, and be income-eligible based on these activities. At the time of application to the at-home infant child care program, a family who is not currently participating in the basic sliding fee program must provide verification of participation in an authorized activity within the nine months before the birth or expected arrival of the child.

E. During the period a family receives a subsidy under the at-home infant child care program, the family is not eligible to receive basic sliding fee child care assistance for the infant or any other child in the family.

Subp. 4. **Continued eligibility under basic sliding fee program.** If families exiting the at-home infant child care program request continued child care assistance and meet all eligibility factors for the basic sliding fee program, the provisions in Minnesota Statutes, section 119B.035, subdivision 4, paragraph (c), apply.

Subp. 5. **Assistance payments.** Items A to C govern assistance payments under the at-home infant child care program.

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A. The number of months of at-home infant child care participation used shall be credited to the eligible parents. If an eligible parent later forms a new family, the number of months of at-home infant child care subsidy received shall be subtracted from the maximum assistance available under this part.

B. There is no additional subsidy for infants with special needs or for multiple births. The county must subtract the family's copayment required by Minnesota Statutes, section 119B.12, to determine the final at-home infant child care subsidy for the family.

C. Family income shall be determined or redetermined at the time a family applies for the at-home infant child care program. Family income shall be annualized from the beginning of the month in which the family would first participate in the at-home infant child care program. Family income includes:

- (1) subsidy payments received as part of the at-home infant child care program;
- (2) income from vacation leave;
- (3) sick or temporary disability benefit payments; and
- (4) other income the family may receive as determined under part 3400.0170 and Minnesota Statutes, section 119B.011, subdivision 15.

Excluded income is defined in part 3400.0170, subpart 6, and Minnesota Statutes, section 119B.011, subdivision 15. The calculation of the family copayment fee is described in part 3400.0100.

D. For purposes of counting the number of months that a family has participated in the at-home infant child care program, any portion of a month in which a family receives a subsidy under the at-home infant child care program is considered a full month of participation in the at-home infant child care program.

For purposes of calculating the at-home infant child care program copayment and subsidy in the first service period, the county shall use the method described in part 3400.0100. In addition, the county shall prorate the subsidy received in the first and last service period of participation according to subitems (1) to (4).

(1) If the family participates in the at-home infant child care program during the service period in which the infant is born or arrives in the home, the subsidy must be prorated to cover the number of calendar days from the date of birth or arrival until the end of the service period.

(2) If the family participates in the at-home infant child care program during the service period of the infant's first birthday, the subsidy must be prorated to cover the number of calendar days from the beginning of the service period to the date of the infant's first birthday.

(3) If the eligible parent leaves employment or another authorized activity in order to participate in the at-home infant child care program, the subsidy must be prorated to cover the number of calendar days from the date the eligible parent leaves the authorized activity to the end of the service period.

(4) If the eligible parent returns to an authorized activity and will no longer be participating in the at-home infant child care program, the subsidy must be prorated to cover the number of calendar days from the beginning of the service period to the date the parent returns to the authorized activity. If all other eligibility conditions are met, the family shall be eligible to receive basic sliding fee child care assistance beginning on the day the eligible parent returns to the authorized activity.

Subp. 6. **County responsibilities.** Items A to C govern county responsibilities for the program.

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A. In addition to duties required under part 3400.0140, counties shall perform the following functions to administer the at-home infant child care program:

- (1) establish the subsidy amount;
- (2) determine an estimated length of time the family will participate;
- (3) determine availability of and encumber ongoing basic sliding fee funding if the family was participating in the basic sliding fee program before participating in the at-home infant child care program or has reached the top of the county's waiting list for the basic sliding fee program;
- (4) consult with the commissioner on the availability of funds;
- (5) forward applicant information as designated to the commissioner;
- (6) notify the commissioner when a family's participation in the at-home infant child care program ends.

B. During program participation, the county shall apply billing procedures established under Minnesota Statutes, chapter 119B, to issue the at-home infant child care subsidy to families.

C. When a family's participation in the at-home infant child care program ends, the county shall send the family and the commissioner a notice indicating the number of months the family participated in the at-home infant child care program in that county.

9530.6800 ASSESSMENT OF NEED FOR TREATMENT PROGRAMS.

Subpart 1. **Assessment of need required for licensure.** Before a license or a provisional license may be issued, the need for the chemical dependency treatment or rehabilitation program must be determined by the commissioner. Need for an additional or expanded chemical dependency treatment program must be determined, in part, based on the recommendation of the county board of commissioners of the county in which the program will be located and the documentation submitted by the applicant at the time of application.

If the county board fails to submit a statement to the commissioner within 60 days of the county board's receipt of the written request from an applicant, as required under part 9530.6810, the commissioner shall determine the need for the applicant's proposed chemical dependency treatment program based on the documentation submitted by the applicant at the time of application.

Subp. 2. **Documentation of need requirements.** An applicant for licensure under parts 9530.2500 to 9530.4000 and Minnesota Statutes, chapter 245G, must submit the documentation in items A and B to the commissioner with the application for licensure:

A. The applicant must submit documentation that it has requested the county board of commissioners of the county in which the chemical dependency treatment program will be located to submit to the commissioner both a written statement that supports or does not support the need for the program and documentation of the rationale used by the county board to make its determination.

B. The applicant must submit a plan for attracting an adequate number of clients to maintain its proposed program capacity, including:

- (1) a description of the geographic area to be served;
- (2) a description of the target population to be served;
- (3) documentation that the capacity or program designs of existing programs are not sufficient to meet the service needs of the chemically abusing or chemically dependent target population if that information is available to the applicant;

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(4) a list of referral sources, with an estimation as to the number of clients the referral source will refer to the applicant's program in the first year of operation; and

(5) any other information available to the applicant that supports the need for new or expanded chemical dependency treatment capacity.

9530.6810 COUNTY BOARD RESPONSIBILITY TO REVIEW PROGRAM NEED.

When an applicant for licensure under parts 9530.2500 to 9530.4000 or Minnesota Statutes, chapter 245G, requests a written statement of support for a proposed chemical dependency treatment program from the county board of commissioners of the county in which the proposed program is to be located, the county board, or the county board's designated representative, shall submit a statement to the commissioner that either supports or does not support the need for the applicant's program. The county board's statement must be submitted in accordance with items A and B:

A. the statement must be submitted within 60 days of the county board's receipt of a written request from the applicant for licensure; and

B. the statement must include the rationale used by the county board to make its determination.