

SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 2452

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
03/14/2019	921	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/11/2019	2753a	Comm report: To pass as amended and re-refer to Finance
04/29/2019	3615a	Comm report: To pass as amended
	3943	Second reading
	3945	Rule 45-amend, subst. General Orders HF2414

- 1.1 A bill for an act
- 1.2 relating to health and human services; establishing the health and human services
- 1.3 budget; modifying provisions governing health care, health insurance, Department
- 1.4 of Human Services operations, Department of Health, and MNsure; requiring care
- 1.5 coordination; modifying medical cannabis requirements; permitting licensed hemp
- 1.6 growers to sell hemp to medical cannabis manufacturers; permitting electronic
- 1.7 monitoring in health care facilities; requiring hospital charges disclosure; modifying
- 1.8 public interest review; authorizing statewide tobacco cessation services; modifying
- 1.9 requirements for PPEC centers; modifying benefits for MnCare and MA for adults;
- 1.10 requiring physicians to allow the opportunity to view ultrasound imaging prior to
- 1.11 an abortion; prohibiting abortions after 20 weeks post fertilization; requiring health
- 1.12 care facilities to post the women's right to know information on their website;
- 1.13 modifying the positive alternatives grant eligibility; modifying the SHIP program;
- 1.14 requiring coverage of 3D mammograms as a preventive service; exempting certain
- 1.15 seasonal food stands from licensure; adjusting license fees for social workers and
- 1.16 optometrists; modifying provisions governing program integrity, children and
- 1.17 family services, chemical and mental health, continuing care for older adults,
- 1.18 disability services, direct care and treatment, operations, and health care; modifying
- 1.19 penalties; establishing asset limits; establishing electronic visit verification system;
- 1.20 eliminating TEFRA fees; repealing MFIP child care assistance program and basic
- 1.21 sliding fee child care assistance program; directing the commissioner of human
- 1.22 services to propose a redesigned child care assistance program; directing closure
- 1.23 of a MSOCS residential facility; repealing statutes relating to the state-operated
- 1.24 services account; establishing a background study set-aside for individuals working
- 1.25 in the substance use disorder treatment field; establishing the officer-involved
- 1.26 community-based care coordination grant program to provide mental health services
- 1.27 to individuals arrested by law enforcement; modifying medical assistance coverage
- 1.28 for community-based care coordination to include tribes; eliminating county share
- 1.29 for cost of officer-involved community-based care coordination; establishing a
- 1.30 shelter-linked youth mental health grant program to provide mental health services
- 1.31 to youth experiencing homelessness or sexual exploitation; establishing the
- 1.32 Community Competency Restoration Task Force; establishing a pilot project for
- 1.33 enhanced community supervision of individuals on probation, parole, supervised
- 1.34 release, or pretrial status who are struggling with mental illness and at heightened
- 1.35 risk to recidivate; directing the commissioner of human services to facilitate
- 1.36 person-centered innovation in health and human services through a statewide
- 1.37 expansion of telepresence platform access and collaboration; modifying human
- 1.38 services licensing provisions; directing the commissioner of human services to

2.1 develop a plain-language handbook for family child care providers; requiring
 2.2 county licensors to seek clarification from Department of Human Services before
 2.3 issuing correction orders in certain circumstances; reforming child care provider
 2.4 licensing inspections; establishing an abbreviated inspection process for qualifying
 2.5 child care providers; establishing risk-based violation levels and corresponding
 2.6 enforcement actions; directing the commissioner of human services to assign rules
 2.7 and statutory provisions to violation risk levels; directing the commissioner of
 2.8 human services to develop key indicators that predict full compliance for use in
 2.9 abbreviated inspections; authorizing additional special family child care home
 2.10 licenses; modifying requirements for drinking water in child care centers; modifying
 2.11 family child care program training requirements; directing the commissioner of
 2.12 human services to develop an annual refresher training course for family child
 2.13 care providers; clarifying and extending child care training timelines; exempting
 2.14 certain individuals from child care training requirements; modifying family child
 2.15 care emergency preparedness plan requirements; creating the Office of
 2.16 Ombudsperson for Child Care Providers; providing appointments; increasing time
 2.17 a child care substitute can provide care; establishing Family Child Care Task Force;
 2.18 directing commissioner of human services to streamline child care licensing and
 2.19 background study record requirements; directing the revisor of statutes to codify
 2.20 certain rules and propose legislation re-codifying chapter 245A; classifying certain
 2.21 licensing violation data as private and nonpublic data after seven years; expanding
 2.22 the definition of child care assistance program payment data; requiring the
 2.23 commissioner of human services to publicly display results of child care licensing
 2.24 reports for no longer than the minimum time required by federal law; requiring
 2.25 reports; making technical changes; appropriating money; amending Minnesota
 2.26 Statutes 2018, sections 13.46, subdivisions 2, 4; 13.461, subdivision 28; 13.69,
 2.27 subdivision 1; 13.851, by adding a subdivision; 15C.02; 16A.055, subdivision 1a;
 2.28 18K.03; 62A.30, by adding a subdivision; 62D.12, by adding a subdivision;
 2.29 62J.495, subdivisions 1, 3; 62K.07; 62Q.01, by adding a subdivision; 62Q.47;
 2.30 62V.05, subdivisions 2, 5, 10; 62V.08; 119B.02, subdivision 6; 119B.09,
 2.31 subdivisions 1, 4, 7, 9, 9a; 119B.125, subdivision 6, by adding subdivisions;
 2.32 119B.13, subdivisions 6, 7; 144.057, subdivision 3; 144.1506, subdivision 2;
 2.33 144.3831, subdivision 1; 144.552; 144.586, by adding a subdivision; 144.966,
 2.34 subdivision 2; 144A.073, by adding a subdivision; 144A.479, by adding a
 2.35 subdivision; 144H.01, subdivision 5; 144H.04, subdivision 1, by adding a
 2.36 subdivision; 144H.06; 144H.07, subdivisions 1, 2; 144H.08, subdivision 2;
 2.37 144H.11, subdivisions 2, 3, 4; 145.4131, subdivision 1; 145.4235, subdivision 2;
 2.38 145.4242; 145.4244; 145.908, subdivision 1; 145.928, subdivisions 1, 7; 145.986,
 2.39 subdivisions 1, 1a, 4, 5, 6; 148.59; 148E.180; 150A.06, subdivision 3, by adding
 2.40 subdivisions; 150A.091, by adding subdivisions; 151.01, subdivision 23; 151.06,
 2.41 by adding a subdivision; 151.211, subdivision 2, by adding a subdivision; 152.126,
 2.42 subdivision 6; 152.22, subdivision 6, by adding a subdivision; 152.25, subdivision
 2.43 4; 152.28, subdivision 1; 152.29, subdivisions 1, 2, 3, 3a; 152.31; 157.22; 245.095;
 2.44 245.4889, subdivision 1; 245A.03, subdivisions 2, 7; 245A.04, subdivisions 4, 7,
 2.45 by adding subdivisions; 245A.06, subdivision 1, by adding a subdivision; 245A.065;
 2.46 245A.11, subdivision 2a; 245A.14, subdivision 4, by adding a subdivision; 245A.16,
 2.47 subdivision 1; 245A.50, subdivisions 1, 2, 3, 4, 5, 6, 7, 9, by adding subdivisions;
 2.48 245A.51, subdivision 3; 245C.02, by adding a subdivision; 245C.22, subdivisions
 2.49 4, 5; 245D.03, subdivision 1; 245D.071, subdivision 5; 245D.09, subdivisions 5,
 2.50 5a; 245D.091, subdivisions 2, 3, 4; 245E.02, by adding a subdivision; 246.54, by
 2.51 adding a subdivision; 252.27, subdivision 2a; 252.275, subdivision 3; 254A.03,
 2.52 subdivision 3; 254A.19, by adding a subdivision; 254B.02, subdivision 1; 254B.03,
 2.53 subdivisions 2, 4; 254B.04, subdivision 1; 254B.05, subdivision 1a; 254B.06,
 2.54 subdivisions 1, 2; 256.9365; 256.98, subdivisions 1, 8; 256.987, subdivisions 1,
 2.55 2; 256B.02, subdivision 7, by adding a subdivision; 256B.04, subdivisions 14, 21;
 2.56 256B.056, subdivisions 1, 3, 4, 5c, 7a; 256B.0625, subdivisions 9, 12, 13, 13e,
 2.57 13f, 17, 18d, 18h, 19a, 24, 43, 56a, by adding subdivisions; 256B.064, subdivisions
 2.58 1a, 1b, 2, by adding a subdivision; 256B.0651, subdivision 17; 256B.0652,

3.1 subdivision 6; 256B.0658; 256B.0659, subdivisions 3, 3a, 11, 12, 13, 14, 19, 21,
 3.2 24, 28, by adding a subdivision; 256B.0757, subdivisions 1, 2, 4, by adding
 3.3 subdivisions; 256B.0911, subdivisions 1a, 3a, 3f, 5, by adding a subdivision;
 3.4 256B.0915, subdivisions 6, 10, by adding a subdivision; 256B.092, subdivision
 3.5 1b, by adding a subdivision; 256B.0921; 256B.14, subdivision 2; 256B.27,
 3.6 subdivision 3; 256B.49, subdivisions 13, 14, by adding a subdivision; 256B.4912,
 3.7 by adding subdivisions; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 10a;
 3.8 256B.493, subdivision 1; 256B.5013, subdivisions 1, 6; 256B.5014; 256B.5015,
 3.9 subdivision 2; 256B.69, subdivisions 4, 31; 256B.85, subdivisions 3, 8, 10;
 3.10 256C.23, by adding a subdivision; 256C.261; 256D.024, subdivision 3; 256D.0515;
 3.11 256D.0516, subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2b, 2f,
 3.12 by adding subdivisions; 256I.05, subdivision 1r; 256I.06, subdivision 8; 256J.08,
 3.13 subdivision 47; 256J.21, subdivision 2; 256J.26, subdivision 3; 256K.45,
 3.14 subdivision 2; 256L.01, subdivision 5; 256L.03, subdivision 5, by adding a
 3.15 subdivision; 256M.41, subdivision 3, by adding a subdivision; 256P.04, subdivision
 3.16 4; 256P.06, subdivision 3; 256R.25; 518A.32, subdivision 3; 518A.51; 525A.11;
 3.17 641.15, subdivision 3a; Laws 2015, chapter 71, article 12, section 8; Laws 2017,
 3.18 First Special Session chapter 6, article 1, sections 44; 45; article 3, section 49;
 3.19 article 8, sections 71; 72; article 18, section 7; proposing coding for new law in
 3.20 Minnesota Statutes, chapters 8; 62J; 62Q; 144; 145; 214; 245; 245A; 254A; 256;
 3.21 256B; 256D; 256J; 256K; 256R; 260C; 268A; proposing coding for new law as
 3.22 Minnesota Statutes, chapter 245I; repealing Minnesota Statutes 2018, sections
 3.23 16A.724, subdivision 2; 119B.011, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10a,
 3.24 11, 12, 13, 13a, 14, 15, 16, 17, 18, 19, 19a, 19b, 20, 20a, 21, 22; 119B.02;
 3.25 119B.025, subdivisions 1, 2, 3, 4; 119B.03, subdivisions 1, 2, 3, 4, 5, 6, 6a, 6b, 8,
 3.26 9, 10; 119B.035; 119B.04; 119B.05, subdivisions 1, 4, 5; 119B.06, subdivisions
 3.27 1, 2, 3; 119B.08, subdivisions 1, 2, 3; 119B.09, subdivisions 1, 3, 4, 4a, 5, 6, 7, 8,
 3.28 9, 9a, 10, 11, 12, 13; 119B.095; 119B.097; 119B.10, subdivisions 1, 2, 3; 119B.105;
 3.29 119B.11, subdivisions 1, 2a, 3, 4; 119B.12, subdivisions 1, 2; 119B.125; 119B.13,
 3.30 subdivisions 1, 1a, 3, 3a, 3b, 3c, 4, 5, 6, 7; 119B.14; 119B.15; 119B.16; 144.1464;
 3.31 144.1911; 245G.11, subdivisions 1, 4, 7; 246.18, subdivisions 8, 9; 254B.03,
 3.32 subdivision 4a; 256B.0625, subdivision 31c; 256B.0705; 256I.05, subdivision 3;
 3.33 256R.53, subdivision 2; Laws 2017, First Special Session chapter 6, article 7,
 3.34 section 34; Minnesota Rules, parts 3400.0010; 3400.0020, subparts 1, 4, 5, 8, 9a,
 3.35 10a, 12, 17a, 18, 18a, 20, 24, 25, 26, 28, 29a, 31b, 32b, 33, 34a, 35, 37, 38, 38a,
 3.36 38b, 39, 40, 40a, 44; 3400.0030; 3400.0035; 3400.0040, subparts 1, 3, 4, 5, 5a,
 3.37 6a, 6b, 6c, 7, 8, 9, 10, 11, 12, 13, 14, 15, 15a, 17, 18; 3400.0060, subparts 2, 4, 5,
 3.38 6, 6a, 7, 8, 9, 10; 3400.0080, subparts 1, 1a, 1b, 8; 3400.0090, subparts 1, 2, 3, 4;
 3.39 3400.0100, subparts 2a, 2b, 2c, 5; 3400.0110, subparts 1, 1a, 2, 2a, 3, 4a, 7, 8, 9,
 3.40 10, 11; 3400.0120, subparts 1, 1a, 2, 2a, 3, 5; 3400.0130, subparts 1, 1a, 2, 3, 3a,
 3.41 3b, 5, 5a, 7; 3400.0140, subparts 1, 2, 4, 5, 6, 7, 8, 9, 9a, 10, 14; 3400.0150;
 3.42 3400.0170, subparts 1, 3, 4, 6a, 7, 8, 9, 10, 11; 3400.0180; 3400.0183, subparts 1,
 3.43 2, 5; 3400.0185; 3400.0187, subparts 1, 2, 3, 4, 6; 3400.0200; 3400.0220;
 3.44 3400.0230, subpart 3; 3400.0235, subparts 1, 2, 3, 4, 5, 6; 9530.6800; 9530.6810.

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

3.46

ARTICLE 1

3.47

PROGRAM INTEGRITY

3.48

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

3.49

15C.02 LIABILITY FOR CERTAIN ACTS.

3.50

(a) A person who commits any act described in clauses (1) to (7) is liable to the state or

3.51

the political subdivision for a civil penalty of ~~not less than \$5,500 and not more than \$11,000~~

4.1 ~~per false or fraudulent claim~~ in the amounts set forth in the federal False Claims Act, United
4.2 States Code, title 31, section 3729, and as modified by the federal Civil Penalties Inflation
4.3 Adjustment Act Improvements Act of 2015, plus three times the amount of damages that
4.4 the state or the political subdivision sustains because of the act of that person, except as
4.5 otherwise provided in paragraph (b):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.2 Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant
6.3 family is the current monthly income of the family multiplied by 12 or the income for the
6.4 12-month period immediately preceding the date of application, or income calculated by
6.5 the method which provides the most accurate assessment of income available to the family.

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

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

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

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

6.25 (b) Payment ceases for a family under the at-home infant child care program when a
6.26 family has used a total of 12 months of assistance as specified under section 119B.035.
6.27 Payment of child care assistance for employed persons on MFIP is effective the date of
6.28 employment or the date of MFIP eligibility, whichever is later. Payment of child care
6.29 assistance for MFIP or DWP participants in employment and training services is effective
6.30 the date of commencement of the services or the date of MFIP or DWP eligibility, whichever
6.31 is later. Payment of child care assistance for transition year child care must be made
6.32 retroactive to the date of eligibility for transition year child care.

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

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

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

7.7 Subd. 9. **Licensed and legal nonlicensed family child care providers; assistance.** This
 7.8 subdivision applies to any provider providing care in a setting other than a licensed or
 7.9 license-exempt child care center. Licensed and legal nonlicensed family child care providers
 7.10 and their employees are not eligible to receive child care assistance subsidies under this
 7.11 chapter for their own children or children in their family during the hours they are providing
 7.12 child care or being paid to provide child care. Child care providers and their employees are
 7.13 eligible to receive child care assistance subsidies for their children when they are engaged
 7.14 in other activities that meet the requirements of this chapter and for which child care
 7.15 assistance can be paid. The hours for which the provider or their employee receives a child
 7.16 care subsidy for their own children must not overlap with the hours the provider provides
 7.17 child care services.

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

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

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

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

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

8.2 Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers
8.3 receiving child care assistance payments must keep accurate and legible daily attendance
8.4 records at the site where services are delivered for children receiving child care assistance
8.5 and must make those records available immediately to the county or the commissioner upon
8.6 request. The attendance records must be completed daily and include the date, the first and
8.7 last name of each child in attendance, and the times when each child is dropped off and
8.8 picked up. To the extent possible, the times that the child was dropped off to and picked up
8.9 from the child care provider must be entered by the person dropping off or picking up the
8.10 child. The daily attendance records must be retained at the site where services are delivered
8.11 for six years after the date of service.

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

8.15 (c) A county or the commissioner may deny or revoke a provider's authorization as a
8.16 child care provider to any applicant, rescind authorization of any provider, to receive child
8.17 care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a
8.18 fraud disqualification under section 256.98, take an action against the provider under chapter
8.19 245E, or establish an attendance record overpayment claim in the system under paragraph
8.20 (d) against a current or former provider, when the county or the commissioner knows or
8.21 has reason to believe that the provider has not complied with the record-keeping requirement
8.22 in this subdivision. A provider's failure to produce attendance records as requested on more
8.23 than one occasion constitutes grounds for disqualification as a provider.

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

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

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

8.32 Subd. 10. **Proof of surety bond coverage.** All licensed child care centers authorized
8.33 for reimbursement under this chapter that received child care assistance program revenue

9.1 equal to or greater than \$250,000 in the previous calendar year must provide to the
9.2 commissioner at least once per year proof of surety bond coverage of \$100,000 in a format
9.3 determined by the commissioner. The surety bond must be in a form approved by the
9.4 commissioner, be renewed annually, and allow for recovery of costs and fees in pursuing
9.5 a claim on the bond.

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

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

9.9 Subd. 11. **Financial misconduct.** (a) County agencies may conduct investigations of
9.10 financial misconduct by child care providers as described in section 245E.02, subdivisions
9.11 1 and 2, only after receiving verification that the department is not investigating a provider
9.12 under chapter 245E.

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

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

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

9.21 (2) the date of the suspension;

9.22 (3) the length of the suspension;

9.23 (4) the requirements and procedures for reinstatement;

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

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

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

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

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

10.7 (b) If a provider has received an authorization of care and been issued a billing form for
10.8 an eligible family, the bill must be submitted within 60 days of the last date of service on
10.9 the bill. A bill submitted more than 60 days after the last date of service must be paid if the
10.10 county determines that the provider has shown good cause why the bill was not submitted
10.11 within 60 days. Good cause must be defined in the county's child care fund plan under
10.12 section 119B.08, subdivision 3, and the definition of good cause must include county error.
10.13 Any bill submitted more than a year after the last date of service on the bill must not be
10.14 paid.

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

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

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

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

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

10.30 (4) the provider is operating after:

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

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

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

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

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

11.6 (7) the provider fails to report decreases in a child's attendance, as required under section
 11.7 119B.125, subdivision 9.

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

11.11 (f) A county's payment policies must be included in the county's child care plan under
 11.12 section 119B.08, subdivision 3. If payments are made by the state, in addition to being in
 11.13 compliance with this subdivision, the payments must be made in compliance with section
 11.14 16A.124.

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

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

11.17 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
 11.18 must not be reimbursed for more than 25 full-day absent days per child, excluding holidays,
 11.19 in a ~~fixed~~ calendar year, or for more than ten consecutive full-day absent days. "Absent
 11.20 day" means any day that the child is authorized and scheduled to be in care with a licensed
 11.21 provider or license exempt center and the child is absent from the care for the entire day.

11.22 Legal nonlicensed family child care providers must not be reimbursed for absent days. If a
 11.23 child attends for part of the time authorized to be in care in a day, but is absent for part of
 11.24 the time authorized to be in care in that same day, the absent time must be reimbursed but
 11.25 the time must not count toward the absent days limit. Child care providers must only be
 11.26 reimbursed for absent days if the provider has a written policy for child absences and charges
 11.27 all other families in care for similar absences.

11.28 (b) Notwithstanding paragraph (a), children with documented medical conditions that
 11.29 cause more frequent absences may exceed the 25 absent days limit, or ten consecutive
 11.30 full-day absent days limit. Absences due to a documented medical condition of a parent or
 11.31 sibling who lives in the same residence as the child receiving child care assistance do not
 11.32 count against the absent days limit in a ~~fixed~~ calendar year. Documentation of medical
 11.33 conditions must be on the forms and submitted according to the timelines established by

12.1 the commissioner. A public health nurse or school nurse may verify the illness in lieu of a
12.2 medical practitioner. If a provider sends a child home early due to a medical reason,
12.3 including, but not limited to, fever or contagious illness, the child care center director or
12.4 lead teacher may verify the illness in lieu of a medical practitioner.

12.5 (c) Notwithstanding paragraph (a), children in families may exceed the absent days limit
12.6 if at least one parent: (1) is under the age of 21; (2) does not have a high school diploma or
12.7 commissioner of education-selected high school equivalency certification; and (3) is a
12.8 student in a school district or another similar program that provides or arranges for child
12.9 care, parenting support, social services, career and employment supports, and academic
12.10 support to achieve high school graduation, upon request of the program and approval of the
12.11 county. If a child attends part of an authorized day, payment to the provider must be for the
12.12 full amount of care authorized for that day.

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

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

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

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

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

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

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

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

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

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

13.7 **245.095 LIMITS ON RECEIVING PUBLIC FUNDS.**

13.8 Subdivision 1. **Prohibition.** (a) If a provider, vendor, or individual enrolled, licensed,
13.9 or receiving funds under a grant contract, or registered in any program administered by the
13.10 commissioner, including under the commissioner's powers and authorities in section 256.01,
13.11 is excluded from any that program administered by the commissioner, including under the
13.12 commissioner's powers and authorities in section 256.01, the commissioner shall:

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

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

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

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

13.23 (b) "Excluded" means disenrolled, ~~subject to license revocation or suspension,~~
13.24 ~~disqualified, or subject to vendor debarment~~ disqualified, has a license that has been revoked
13.25 or suspended under chapter 245A, has been debarred or suspended under Minnesota Rules,
13.26 part 1230.1150, or terminated from participation in medical assistance under section
13.27 256B.064.

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

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

14.1 Sec. 14. [245A.24] MANDATORY REPORTING.

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

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

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

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

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

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

14.12 Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the
14.13 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
14.14 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
14.15 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
14.16 256L, child care assistance programs, and emergency assistance programs under section
14.17 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
14.18 (1) to (5):

14.19 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
14.20 willfully false statement or representation, by intentional concealment of any material fact,
14.21 or by impersonation or other fraudulent device, assistance or the continued receipt of
14.22 assistance, to include child care assistance or vouchers produced according to sections
14.23 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94,
14.24 and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that
14.25 to which the person is entitled;

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

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

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

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

15.6 Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of
 15.7 wrongfully obtaining assistance by a federal or state court or by an administrative hearing
 15.8 determination, or waiver thereof, through a disqualification consent agreement, or as part
 15.9 of any approved diversion plan under section 401.065, or any court-ordered stay which
 15.10 carries with it any probationary or other conditions, in the Minnesota family investment
 15.11 program and any affiliated program to include the diversionary work program and the work
 15.12 participation cash benefit program, the food stamp or food support program, the general
 15.13 assistance program, housing support under chapter 256I, or the Minnesota supplemental
 15.14 aid program shall be disqualified from that program. The disqualification based on a finding
 15.15 or action by a federal or state court is a permanent disqualification. The disqualification
 15.16 based on an administrative hearing, or waiver thereof, through a disqualification consent
 15.17 agreement, or as part of any approved diversion plan under section 401.065, or any
 15.18 court-ordered stay which carries with it any probationary or other conditions must be for a
 15.19 period of two years for the first offense and a permanent disqualification for the second
 15.20 offense. In addition, any person disqualified from the Minnesota family investment program
 15.21 shall also be disqualified from the food stamp or food support program. The needs of that
 15.22 individual shall not be taken into consideration in determining the grant level for that
 15.23 assistance unit.

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

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

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

15.27 The period of program disqualification shall begin on the date stipulated on the advance
 15.28 notice of disqualification without possibility of postponement for administrative stay or
 15.29 administrative hearing and shall continue through completion unless and until the findings
 15.30 upon which the sanctions were imposed are reversed by a court of competent jurisdiction.
 15.31 The period for which sanctions are imposed is not subject to review. The sanctions provided
 15.32 under this subdivision are in addition to, and not in substitution for, any other sanctions that
 15.33 may be provided for by law for the offense involved. A disqualification established through
 15.34 hearing or waiver shall result in the disqualification period beginning immediately unless

16.1 the person has become otherwise ineligible for assistance. If the person is ineligible for
16.2 assistance, the disqualification period begins when the person again meets the eligibility
16.3 criteria of the program from which they were disqualified and makes application for that
16.4 program.

16.5 (b) A family receiving assistance through child care assistance programs under chapter
16.6 119B with a family member who is found to be guilty of wrongfully obtaining child care
16.7 assistance by a federal court, state court, or an administrative hearing determination or
16.8 waiver, through a disqualification consent agreement, as part of an approved diversion plan
16.9 under section 401.065, or a court-ordered stay with probationary or other conditions, is
16.10 disqualified from child care assistance programs. The disqualifications ~~must be for periods~~
16.11 ~~of one year and two years for the first and second offenses, respectively. Subsequent~~
16.12 ~~violations must result in~~ based on a finding or action by a federal or state court is a permanent
16.13 disqualification. The disqualification based on an administrative hearing determination or
16.14 waiver, through a disqualification consent agreement, as part of an approved diversion plan
16.15 under section 401.065, or a court-ordered stay with probationary or other conditions must
16.16 be for a period of two years for the first offense and a permanent disqualification for the
16.17 second offense. During the disqualification period, disqualification from any child care
16.18 program must extend to all child care programs and must be immediately applied.

16.19 (c) A provider caring for children receiving assistance through child care assistance
16.20 programs under chapter 119B is disqualified from receiving payment for child care services
16.21 from the child care assistance program under chapter 119B when the provider is found to
16.22 have wrongfully obtained child care assistance by a federal court, state court, or an
16.23 administrative hearing determination or waiver under section 256.046, through a
16.24 disqualification consent agreement, as part of an approved diversion plan under section
16.25 401.065, or a court-ordered stay with probationary or other conditions. The disqualification
16.26 ~~must be for a period of one year for the first offense and two years for the second offense.~~
16.27 ~~Any subsequent violation must result in~~ based on a finding or action by a federal or state
16.28 court is a permanent disqualification. The disqualification based on an administrative hearing
16.29 determination or waiver under section 256.045, as part of an approved diversion plan under
16.30 section 401.065, or a court-ordered stay with probationary or other conditions must be for
16.31 a period of two years for the first offense and a permanent disqualification for the second
16.32 offense. The disqualification period must be imposed immediately after a determination is
16.33 made under this paragraph. During the disqualification period, the provider is disqualified
16.34 from receiving payment from any child care program under chapter 119B.

17.1 (d) Any person found to be guilty of wrongfully obtaining MinnesotaCare for adults
17.2 without children and upon federal approval, all categories of medical assistance and
17.3 remaining categories of MinnesotaCare, except for children through age 18, by a federal or
17.4 state court or by an administrative hearing determination, or waiver thereof, through a
17.5 disqualification consent agreement, or as part of any approved diversion plan under section
17.6 401.065, or any court-ordered stay which carries with it any probationary or other conditions,
17.7 is disqualified from that program. The period of disqualification is one year after the first
17.8 offense, two years after the second offense, and permanently after the third or subsequent
17.9 offense. The period of program disqualification shall begin on the date stipulated on the
17.10 advance notice of disqualification without possibility of postponement for administrative
17.11 stay or administrative hearing and shall continue through completion unless and until the
17.12 findings upon which the sanctions were imposed are reversed by a court of competent
17.13 jurisdiction. The period for which sanctions are imposed is not subject to review. The
17.14 sanctions provided under this subdivision are in addition to, and not in substitution for, any
17.15 other sanctions that may be provided for by law for the offense involved.

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

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

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

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

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

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

18.5 Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or
18.6 persons furnishing, within the scope of the vendor's respective license, any or all of the
18.7 following goods or services: medical, surgical, hospital, ambulatory surgical center services,
18.8 optical, visual, dental and nursing services; drugs and medical supplies; appliances;
18.9 laboratory, diagnostic, and therapeutic services; nursing home and convalescent care;
18.10 screening and health assessment services provided by public health nurses as defined in
18.11 section 145A.02, subdivision 18; health care services provided at the residence of the patient
18.12 if the services are performed by a public health nurse and the nurse indicates in a statement
18.13 submitted under oath that the services were actually provided; and such other medical
18.14 services or supplies provided or prescribed by persons authorized by state law to give such
18.15 services and supplies, including services under section 256B.4912. For purposes of this
18.16 chapter, the term includes a person or entity that furnishes a good or service eligible for
18.17 medical assistance or federally approved waiver plan payments under this chapter. The term
18.18 includes, but is not limited to, directors and officers of corporations or members of
18.19 partnerships who, either individually or jointly with another or others, have the legal control,
18.20 supervision, or responsibility of submitting claims for reimbursement to the medical
18.21 assistance program. The term only includes directors and officers of corporations who
18.22 personally receive a portion of the distributed assets upon liquidation or dissolution, and
18.23 their liability is limited to the portion of the claim that bears the same proportion to the total
18.24 claim as their share of the distributed assets bears to the total distributed assets.

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

18.32 (c) A federally recognized Indian tribe that intends to implement standards for
18.33 credentialing health professionals must submit the standards to the commissioner of human
18.34 services, along with evidence of meeting, exceeding, or being exempt from corresponding

19.1 state standards. The commissioner shall maintain a copy of the standards and supporting
19.2 evidence, and shall use those standards to enroll tribal-approved health professionals as
19.3 medical assistance providers. For purposes of this section, "Indian" and "Indian tribe" mean
19.4 persons or entities that meet the definition in United States Code, title 25, section 450b.

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

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

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

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

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

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

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

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

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

20.3 (1) consumer directed community supports; and

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

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

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

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

20.18 ~~(b)~~ (g) An enrolled provider that is also licensed by the commissioner under chapter
20.19 245A, or is licensed as a home care provider by the Department of Health under chapter
20.20 144A and has a home and community-based services designation on the home care license
20.21 under section 144A.484, must designate an individual as the entity's compliance officer.
20.22 The compliance officer must:

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

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

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

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

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

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

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

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

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

21.19 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require
21.20 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
21.21 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
21.22 Services, its agents, or its designated contractors and the state agency, its agents, or its
21.23 designated contractors to conduct unannounced on-site inspections of any provider location.
21.24 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
21.25 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
21.26 and standards used to designate Medicare providers in Code of Federal Regulations, title
21.27 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
21.28 The commissioner's designations are not subject to administrative appeal.

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

22.1 ~~(g)~~ (l)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all
 22.2 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
 22.3 meeting the durable medical equipment provider and supplier definition in clause (3),
 22.4 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
 22.5 annually renewed and designates the Minnesota Department of Human Services as the
 22.6 obligee, and must be submitted in a form approved by the commissioner. For purposes of
 22.7 this clause, the following medical suppliers are not required to obtain a surety bond: a
 22.8 federally qualified health center, a home health agency, the Indian Health Service, a
 22.9 pharmacy, and a rural health clinic.

22.10 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
 22.11 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
 22.12 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
 22.13 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
 22.14 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
 22.15 purchase a surety bond of \$100,000. The surety bond must be in a form approved by the
 22.16 commissioner, renewed annually, and must allow for recovery of costs and fees in pursuing
 22.17 a claim on the bond.

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

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

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

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

23.2 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
23.3 assistance, a person must not individually own more than \$3,000 in assets, or if a member
23.4 of a household with two family members, husband and wife, or parent and child, the
23.5 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
23.6 dependent. In addition to these maximum amounts, an eligible individual or family may
23.7 accrue interest on these amounts, but they must be reduced to the maximum at the time of
23.8 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
23.9 according to section 256B.35 must also be reduced to the maximum at the time of the
23.10 eligibility redetermination. The value of assets that are not considered in determining
23.11 eligibility for medical assistance is the value of those assets excluded under the Supplemental
23.12 Security Income program for aged, blind, and disabled persons, with the following
23.13 exceptions:

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

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

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

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

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

23.30 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
23.31 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before
23.32 the person's 65th birthday, the assets owned by the person and the person's spouse must be
23.33 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when
23.34 determining eligibility for medical assistance under section 256B.055, subdivision 7. The

24.1 income of a spouse of a person enrolled in medical assistance under section 256B.057,
24.2 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
24.3 must be disregarded when determining eligibility for medical assistance under section
24.4 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
24.5 in section 256B.059; and

24.6 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
24.7 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
24.8 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
24.9 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

24.10 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
24.11 15.

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

24.13 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
24.14 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
24.15 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
24.16 Supplemental Security Income may have an income up to the Supplemental Security Income
24.17 standard in effect on that date.

24.18 (b) Effective January 1, 2014, to be eligible for medical assistance, under section
24.19 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
24.20 percent of the federal poverty guidelines for the household size.

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

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

24.27 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
24.28 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
24.29 household size or an equivalent standard when converted using modified adjusted gross
24.30 income methodology as required under the Affordable Care Act. Children who are enrolled
24.31 in medical assistance as of December 31, 2013, and are determined ineligible for medical
24.32 assistance because of the elimination of income disregards under modified adjusted gross
24.33 income methodology as defined in subdivision 1a remain eligible for medical assistance

25.1 under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law
25.2 111-3, until the date of their next regularly scheduled eligibility redetermination as required
25.3 in subdivision 7a.

25.4 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
25.5 who are not residents of long-term care facilities, the commissioner shall: (1) disregard
25.6 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.
25.7 For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans
25.8 Administration unusual medical expense payments are considered income to the recipient;
25.9 and (2) include all assets available to the applicant that are considered income according to
25.10 the Internal Revenue Service. Income includes all deposits into accounts owned or controlled
25.11 by the applicant, including amounts spent on personal expenses, including rent, mortgage,
25.12 automobile-related expenses, utilities, and food and amounts received as salary or draws
25.13 from business accounts and not otherwise excluded by federal or state laws. Income does
25.14 not include a deposit specifically identified by the applicant as a loan or gift, for which the
25.15 applicant provides the source, date, amount, and repayment terms.

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

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

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

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

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

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

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

26.6 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
 26.7 emergency medical care or transportation costs incurred by eligible persons in obtaining
 26.8 emergency or nonemergency medical care when paid directly to an ambulance company,
 26.9 nonemergency medical transportation company, or other recognized providers of
 26.10 transportation services. Medical transportation must be provided by:

26.11 (1) nonemergency medical transportation providers who meet the requirements of this
 26.12 subdivision;

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

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

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

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

26.17 (c) Medical assistance covers nonemergency medical transportation provided by
 26.18 nonemergency medical transportation providers enrolled in the Minnesota health care
 26.19 programs. All nonemergency medical transportation providers must comply with the
 26.20 operating standards for special transportation service as defined in sections 174.29 to 174.30
 26.21 and Minnesota Rules, chapter 8840, ~~and in consultation with the Minnesota Department of~~
 26.22 ~~Transportation.~~ All drivers providing nonemergency medical transportation must be
 26.23 individually enrolled with the commissioner if the driver is a subcontractor for or employed
 26.24 by a provider that both has a base of operation located within a metropolitan county listed
 26.25 in section 473.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All
 26.26 nonemergency medical transportation providers shall bill for nonemergency medical
 26.27 transportation services in accordance with Minnesota health care programs criteria. Publicly
 26.28 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
 26.29 requirements outlined in this paragraph.

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

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

27.1 (2) the provider has initiated background studies on the individuals specified in section
27.2 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

27.8 (1) adhere to the policies defined by the commissioner in consultation with the
27.9 Nonemergency Medical Transportation Advisory Committee;

27.10 (2) pay nonemergency medical transportation providers for services provided to
27.11 Minnesota health care programs beneficiaries to obtain covered medical services;

27.12 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
27.13 trips, and number of trips by mode; and

27.14 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
27.15 administrative structure assessment tool that meets the technical requirements established
27.16 by the commissioner, reconciles trip information with claims being submitted by providers,
27.17 and ensures prompt payment for nonemergency medical transportation services.

27.18 (f) Until the commissioner implements the single administrative structure and delivery
27.19 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
27.20 commissioner or an entity approved by the commissioner that does not dispatch rides for
27.21 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

27.22 (g) The commissioner may use an order by the recipient's attending physician or a medical
27.23 or mental health professional to certify that the recipient requires nonemergency medical
27.24 transportation services. Nonemergency medical transportation providers shall perform
27.25 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
27.26 includes passenger pickup at and return to the individual's residence or place of business,
27.27 assistance with admittance of the individual to the medical facility, and assistance in
27.28 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

27.29 Nonemergency medical transportation providers must take clients to the health care
27.30 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
27.31 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
27.32 authorization from the local agency.

28.1 Nonemergency medical transportation providers may not bill for separate base rates for
28.2 the continuation of a trip beyond the original destination. Nonemergency medical
28.3 transportation providers must maintain trip logs, which include pickup and drop-off times,
28.4 signed by the medical provider or client, whichever is deemed most appropriate, attesting
28.5 to mileage traveled to obtain covered medical services. Clients requesting client mileage
28.6 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
28.7 services.

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

28.13 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

29.9 (k) The commissioner shall:

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

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

29.13 (3) investigate all complaints and appeals.

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

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

29.23 (1) \$0.22 per mile for client reimbursement;

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

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

29.29 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

29.30 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

29.31 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

30.1 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
 30.2 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

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

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

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

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

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

30.30 **Subd. 17e. Transportation provider termination.** (a) A terminated nonemergency
 30.31 medical transportation provider, including all named individuals on the current enrollment

31.1 disclosure form and known or discovered affiliates of the nonemergency medical
 31.2 transportation provider, is not eligible to enroll as a nonemergency medical transportation
 31.3 provider for five years following the termination.

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

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

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

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

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

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

31.20 (2) subdivision 18; and

31.21 (3) subdivision 18a.

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

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

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

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

32.7 (c) Mental health provider travel time under this subdivision is only covered when the
32.8 mental health service being provided is covered under medical assistance and only when
32.9 the covered mental health service is delivered and billed. Mental health provider travel time
32.10 is not covered when the mental health service being provided otherwise includes provider
32.11 travel time or when the service is site based.

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

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

32.21 (2) printed name of the recipient;

32.22 (3) date the entry is made;

32.23 (4) date the service is provided;

32.24 (5) origination site and destination site;

32.25 (6) who provided the service;

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

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

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

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

33.2 Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions
33.3 for the conduct described in subdivision 1a: suspension or withholding of payments to a
33.4 vendor and suspending or terminating participation in the program, or imposition of a fine
33.5 under subdivision 2, paragraph (f). When imposing sanctions under this section, the
33.6 commissioner shall consider the nature, chronicity, or severity of the conduct and the effect
33.7 of the conduct on the health and safety of persons served by the vendor. The commissioner
33.8 shall suspend a vendor's participation in the program for a minimum of five years if the
33.9 vendor is convicted of a crime, received a stay of adjudication, or entered a court-ordered
33.10 diversion program for an offense related to a provision of a health service under medical
33.11 assistance or health care fraud. Regardless of imposition of sanctions, the commissioner
33.12 may make a referral to the appropriate state licensing board.

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

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

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

33.27 (1) the vendor is convicted of a crime involving the conduct described in subdivision
33.28 1a; or

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

33.32 (i) fraud hotline complaints;

33.33 (ii) claims data mining; and

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

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

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

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

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

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

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

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

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

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

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

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

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

35.4 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is
35.5 to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision
35.6 3, by filing with the commissioner a written request of appeal. The appeal request must be
35.7 received by the commissioner no later than 30 days after the date the notification of monetary
35.8 recovery or sanction was mailed to the vendor. The appeal request must specify:

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

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

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

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

35.15 (5) other information required by the commissioner.

35.16 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
35.17 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
35.18 commissioner may assess fines if specific required components of documentation are
35.19 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
35.20 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is
35.21 less. If the commissioner determines that a vendor repeatedly violated this chapter or
35.22 Minnesota Rules, chapter 9505, related to the provision of services to program recipients
35.23 and the submission of claims for payment, the commissioner may order a vendor to forfeit
35.24 a fine based on the nature, severity, and chronicity of the violations, in an amount of up to
35.25 \$5,000 or 20 percent of the value of the claims, whichever is greater.

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

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

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

36.10 (b) Before hiring or entering into a business transaction, a vendor shall check the
36.11 exclusion list. The vendor shall check the exclusion list on a monthly basis and document
36.12 the date and time with a.m. and p.m. designations that the exclusion list was checked and
36.13 the name and title of the person who checked the exclusion list. The vendor shall: (1)
36.14 immediately terminate a current employee on the exclusion list; and (2) immediately
36.15 terminate a business relationship with an individual or entity on the exclusion list.

36.16 (c) A vendor's requirement to check the exclusion list and to terminate an employee on
36.17 the exclusion list applies to each employee, even if the named employee is not responsible
36.18 for direct patient care or direct submission of a claim to medical assistance. A vendor's
36.19 requirement to check the exclusion list and terminate a business relationship with an
36.20 individual or entity on the exclusion list applies to each business relationship, even if the
36.21 named individual or entity is not responsible for direct patient care or direct submission of
36.22 a claim to medical assistance.

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

36.28 (1) sanctions under subdivision 2;

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

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

37.1 Sec. 35. [256B.0646] CORRECTIVE ACTIONS FOR PEOPLE USING PERSONAL
 37.2 CARE ASSISTANCE SERVICES; MINNESOTA RESTRICTED RECIPIENT
 37.3 PROGRAM.

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

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

37.10 (2) obtain a new assessment as described in section 256B.0911, including consultation
 37.11 with a registered or public health nurse on the long-term care consultation team under section
 37.12 256B.0911, subdivision 3, paragraph (b), clause (2); and

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

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

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

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

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

37.23 Subd. 17. **Recipient protection.** (a) Providers of home care services must provide each
 37.24 recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days
 37.25 prior to terminating services to a recipient, if the termination results from provider sanctions
 37.26 under section 256B.064, such as a payment withhold, a suspension of participation, or a
 37.27 termination of participation. If a home care provider determines it is unable to continue
 37.28 providing services to a recipient, the provider must notify the recipient, the recipient's
 37.29 responsible party, and the commissioner 30 days prior to terminating services to the recipient
 37.30 because of an action under section 256B.064, and must assist the commissioner and lead
 37.31 agency in supporting the recipient in transitioning to another home care provider of the
 37.32 recipient's choice.

38.1 (b) In the event of a payment withhold from a home care provider, a suspension of
 38.2 participation, or a termination of participation of a home care provider under section
 38.3 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care
 38.4 and the lead agencies for all recipients with active service agreements with the provider. At
 38.5 the commissioner's request, the lead agencies must contact recipients to ensure that the
 38.6 recipients are continuing to receive needed care, and that the recipients have been given
 38.7 free choice of provider if they transfer to another home care provider. In addition, the
 38.8 commissioner or the commissioner's delegate may directly notify recipients who receive
 38.9 care from the provider that payments have been or will be withheld or that the provider's
 38.10 participation in medical assistance has been or will be suspended or terminated, if the
 38.11 commissioner determines that notification is necessary to protect the welfare of the recipients.
 38.12 For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care
 38.13 organizations.

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

38.15 Subd. 3. ~~Noncovered~~ **Personal care assistance services not covered.** (a) Personal care
 38.16 assistance services are not eligible for medical assistance payment under this section when
 38.17 provided:

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

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

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

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

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

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

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

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

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

39.4 (1) sterile procedures;

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

39.6 (3) home maintenance or chore services;

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

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

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

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

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

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

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

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

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

39.27 (2) provider name and telephone numbers;

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

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

- 40.1 (5) signatures of recipient or the responsible party;
- 40.2 (6) personal signature of the personal care assistant;
- 40.3 (7) any shared care provided, if applicable;
- 40.4 (8) a statement that it is a federal crime to provide false information on personal care
- 40.5 service billings for medical assistance payments; and
- 40.6 (9) dates and location of recipient stays in a hospital, care facility, or incarceration.

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

40.8 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must

40.9 work for a personal care assistance provider agency and, meet the definition of qualified

40.10 professional under section 256B.0625, subdivision 19c, and enroll with the department as

40.11 a qualified professional after clearing a background study. Before a qualified professional

40.12 provides services, the personal care assistance provider agency must initiate a background

40.13 study on the qualified professional under chapter 245C, and the personal care assistance

40.14 provider agency must have received a notice from the commissioner that the qualified

40.15 professional:

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

40.17 (2) is disqualified, but the qualified professional has received a set aside of the

40.18 disqualification under section 245C.22.

40.19 (b) The qualified professional shall perform the duties of training, supervision, and

40.20 evaluation of the personal care assistance staff and evaluation of the effectiveness of personal

40.21 care assistance services. The qualified professional shall:

40.22 (1) develop and monitor with the recipient a personal care assistance care plan based on

40.23 the service plan and individualized needs of the recipient;

40.24 (2) develop and monitor with the recipient a monthly plan for the use of personal care

40.25 assistance services;

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

40.27 (4) provide training and ensure competency for the personal care assistant in the individual

40.28 needs of the recipient; and

40.29 (5) document all training, communication, evaluations, and needed actions to improve

40.30 performance of the personal care assistants.

41.1 (c) Effective July 1, 2011, the qualified professional shall complete the provider training
 41.2 with basic information about the personal care assistance program approved by the
 41.3 commissioner. Newly hired qualified professionals must complete the training within six
 41.4 months of the date hired by a personal care assistance provider agency. Qualified
 41.5 professionals who have completed the required training as a worker from a personal care
 41.6 assistance provider agency do not need to repeat the required training if they are hired by
 41.7 another agency, if they have completed the training within the last three years. The required
 41.8 training must be available with meaningful access according to title VI of the Civil Rights
 41.9 Act and federal regulations adopted under that law or any guidance from the United States
 41.10 Health and Human Services Department. The required training must be available online or
 41.11 by electronic remote connection. The required training must provide for competency testing
 41.12 to demonstrate an understanding of the content without attending in-person training. A
 41.13 qualified professional is allowed to be employed and is not subject to the training requirement
 41.14 until the training is offered online or through remote electronic connection. A qualified
 41.15 professional employed by a personal care assistance provider agency certified for
 41.16 participation in Medicare as a home health agency is exempt from the training required in
 41.17 this subdivision. When available, the qualified professional working for a Medicare-certified
 41.18 home health agency must successfully complete the competency test. The commissioner
 41.19 shall ensure there is a mechanism in place to verify the identity of persons completing the
 41.20 competency testing electronically.

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

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

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

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

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

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

42.1 (c) The qualified professional shall evaluate the personal care assistant within the first
42.2 14 days of starting to provide regularly scheduled services for a recipient, or sooner as
42.3 determined by the qualified professional, except for the personal care assistance choice
42.4 option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified
42.5 professional shall evaluate the personal care assistance services for a recipient through direct
42.6 observation of a personal care assistant's work. The qualified professional may conduct
42.7 additional training and evaluation visits, based upon the needs of the recipient and the
42.8 personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal
42.9 care assistance services provided to a recipient do not require direct observation of each
42.10 personal care assistant's work and shall occur:

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

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

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

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

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

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

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

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

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

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

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

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

- 43.1 (1) the personal care assistance care plan based on the service plan and individualized
 43.2 needs of the recipient;
- 43.3 (2) a month-to-month plan for use of personal care assistance services;
- 43.4 (3) changes in need of the recipient requiring a change to the level of service and the
 43.5 personal care assistance care plan;
- 43.6 (4) evaluation results of supervision visits and identified issues with personal care
 43.7 assistance staff with actions taken;
- 43.8 (5) all communication with the recipient and personal care assistance staff; and
- 43.9 (6) hands-on training or individualized training for the care of the recipient.
- 43.10 (g) The documentation in paragraph (f) must be done on agency templates.
- 43.11 (h) The services that are not eligible for payment as qualified professional services
 43.12 include:
- 43.13 (1) direct professional nursing tasks that could be assessed and authorized as skilled
 43.14 nursing tasks;
- 43.15 (2) agency administrative activities;
- 43.16 (3) training other than the individualized training required to provide care for a recipient;
 43.17 and
- 43.18 (4) any other activity that is not described in this section.
- 43.19 (i) The qualified professional shall notify the commissioner on a form prescribed by the
 43.20 commissioner, within 30 days of when a qualified professional is no longer employed by
 43.21 or otherwise affiliated with the personal care assistance agency for whom the qualified
 43.22 professional previously provided qualified professional services.
- 43.23 Sec. 41. Minnesota Statutes 2018, section 256B.0659, subdivision 19, is amended to read:
- 43.24 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under
 43.25 personal care assistance choice, the recipient or responsible party shall:
- 43.26 (1) recruit, hire, schedule, and terminate personal care assistants according to the terms
 43.27 of the written agreement required under subdivision 20, paragraph (a);
- 43.28 (2) develop a personal care assistance care plan based on the assessed needs and
 43.29 addressing the health and safety of the recipient with the assistance of a qualified professional
 43.30 as needed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 45.1 (5) withhold and pay all applicable federal and state taxes;
- 45.2 (6) verify and keep records of hours worked by the personal care assistant and qualified
45.3 professional;
- 45.4 (7) make the arrangements and pay taxes and other benefits, if any, and comply with
45.5 any legal requirements for a Minnesota employer;
- 45.6 (8) enroll in the medical assistance program as a personal care assistance choice agency;
45.7 and
- 45.8 (9) enter into a written agreement as specified in subdivision 20 before services are
45.9 provided.

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

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

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

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

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

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

45.26 (5) proof of liability insurance;

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

45.30 (7) a copy of the personal care assistance provider agency's written policies and
45.31 procedures including: hiring of employees; training requirements; service delivery;

46.1 identification, prevention, detection, and reporting of fraud or any billing, record-keeping,
46.2 or other administrative noncompliance; and employee and consumer safety including process
46.3 for notification and resolution of consumer grievances, identification and prevention of
46.4 communicable diseases, and employee misconduct;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47.19 ~~(e)~~ (d) All personal care assistance provider agencies shall require all employees in
47.20 management and supervisory positions and owners of the agency who are active in the
47.21 day-to-day management and operations of the agency to complete mandatory training as
47.22 determined by the commissioner before enrollment of the agency as a provider. Employees
47.23 in management and supervisory positions and owners who are active in the day-to-day
47.24 operations of an agency who have completed the required training as an employee with a
47.25 personal care assistance provider agency do not need to repeat the required training if they
47.26 are hired by another agency, if they have completed the training within the past three years.
47.27 By September 1, 2010, the required training must be available with meaningful access
47.28 according to title VI of the Civil Rights Act and federal regulations adopted under that law
47.29 or any guidance from the United States Health and Human Services Department. The
47.30 required training must be available online or by electronic remote connection. The required
47.31 training must provide for competency testing. Personal care assistance provider agency
47.32 billing staff shall complete training about personal care assistance program financial
47.33 management. This training is effective July 1, 2009. Any personal care assistance provider
47.34 agency enrolled before that date shall, if it has not already, complete the provider training

48.1 within 18 months of July 1, 2009. Any new owners or employees in management and
48.2 supervisory positions involved in the day-to-day operations are required to complete
48.3 mandatory training as a requisite of working for the agency. Personal care assistance provider
48.4 agencies certified for participation in Medicare as home health agencies are exempt from
48.5 the training required in this subdivision. When available, Medicare-certified home health
48.6 agency owners, supervisors, or managers must successfully complete the competency test.

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

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

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

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

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

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

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

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

48.21 (4) comply with background study requirements;

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

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

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

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

48.29 (9) effective January 1, 2010, document that the agency uses a minimum of 72.5 percent
48.30 of the revenue generated by the medical assistance rate for personal care assistance services
48.31 for employee personal care assistant wages and benefits. The revenue generated by the

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

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

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

49.6 (12) report suspected neglect and abuse to the common entry point according to section
49.7 256B.0651;

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

49.9 **and**

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

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

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

49.15 **Subd. 3. Access to medical records.** The commissioner of human services, with the
49.16 written consent of the recipient, on file with the local welfare agency, shall be allowed
49.17 access to all personal medical records of medical assistance recipients solely for the purposes
49.18 of investigating whether or not: (a) a vendor of medical care has submitted a claim for
49.19 reimbursement, a cost report or a rate application which is duplicative, erroneous, or false
49.20 in whole or in part, or which results in the vendor obtaining greater compensation than the
49.21 vendor is legally entitled to; or (b) the medical care was medically necessary. ~~The vendor~~
49.22 ~~of medical care shall receive notification from the commissioner at least 24 hours before~~
49.23 ~~the commissioner gains access to such records.~~ When the commissioner is investigating a
49.24 suspected overpayment of Medicaid funds, only after first conferring with the department's
49.25 Office of Inspector General, and documenting the evidentiary basis for any decision to
49.26 demand immediate access to medical records, the commissioner must be given immediate
49.27 access without prior notice to the vendor's office during regular business hours and to
49.28 documentation and records related to services provided and submission of claims for services
49.29 provided. Denying the commissioner access to records is cause for the vendor's immediate
49.30 suspension of payment or termination according to section 256B.064. The determination
49.31 of provision of services not medically necessary shall be made by the commissioner.
49.32 Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject

50.1 to any civil or criminal liability for providing access to medical records to the commissioner
50.2 of human services pursuant to this section.

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

50.5 Subd. 1a. **Annual labor market reporting.** (a) As determined by the commissioner, a
50.6 provider of home and community-based services for the elderly under sections 256B.0913
50.7 and 256B.0915, home and community-based services for people with developmental
50.8 disabilities under section 256B.092, and home and community-based services for people
50.9 with disabilities under section 256B.49 shall submit data to the commissioner on the
50.10 following:

50.11 (1) number of direct-care staff;

50.12 (2) wages of direct-care staff;

50.13 (3) hours worked by direct-care staff;

50.14 (4) overtime wages of direct-care staff;

50.15 (5) overtime hours worked by direct-care staff;

50.16 (6) benefits paid and accrued by direct-care staff;

50.17 (7) direct-care staff retention rates;

50.18 (8) direct-care staff job vacancies;

50.19 (9) amount of travel time paid;

50.20 (10) program vacancy rates; and

50.21 (11) other related data requested by the commissioner.

50.22 (b) The commissioner may adjust reporting requirements for a self-employed direct-care
50.23 staff.

50.24 (c) For the purposes of this subdivision, "direct-care staff" means employees, including
50.25 self-employed individuals and individuals directly employed by a participant in a
50.26 consumer-directed service delivery option, providing direct service provision to people
50.27 receiving services under this section. Direct-care staff does not include executive, managerial,
50.28 or administrative staff.

50.29 (d) This subdivision also applies to a provider of personal care assistance services under
50.30 section 256B.0625, subdivision 19a; community first services and supports under section

51.1 256B.85; nursing services and home health services under section 256B.0625, subdivision
 51.2 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and
 51.3 habilitation services for residents of intermediate care facilities for persons with
 51.4 developmental disabilities under section 256B.501.

51.5 (e) This subdivision also applies to financial management services providers for
 51.6 participants who directly employ direct-care staff through consumer support grants under
 51.7 section 256.476; the personal care assistance choice program under section 256B.0657,
 51.8 subdivisions 18 to 20; community first services and supports under section 256B.85; and
 51.9 the consumer-directed community supports option available under the alternative care
 51.10 program, the brain injury waiver, the community alternative care waiver, the community
 51.11 alternatives for disabled individuals waiver, the developmental disabilities waiver, the
 51.12 elderly waiver, and the Minnesota senior health option, except financial management services
 51.13 providers are not required to submit the data listed in paragraph (a), clauses (7) to (11).

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

51.16 (g) A provider shall submit the data annually on a date specified by the commissioner.
 51.17 The commissioner shall give a provider at least 30 calendar days to submit the data. If a
 51.18 provider fails to submit the requested data by the date specified by the commissioner, the
 51.19 commissioner may delay medical assistance reimbursement until the requested data is
 51.20 submitted.

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

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

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

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

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

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

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

52.3 (3) the home and community-based service provider has met the documentation
52.4 requirements under subdivision 12, 13, 14, or 15.

52.5 A service that does not meet the criteria in this subdivision may be recovered by the
52.6 department according to section 256B.064 and Minnesota Rules, parts 9505.2160 to
52.7 9505.2245.

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

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

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

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

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

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

52.26 (1) the date the documentation occurred;

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

52.28 (3) the start and stop times with a.m. and p.m. designations, except for case management
52.29 services as defined under sections 256B.0913, subdivision 7, 256B.0915, subdivision 1a,
52.30 256B.092, subdivision 1a, and 256B.49, subdivision 13;

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

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

53.4 (d) If the service is reimbursed at a daily rate or does not meet the requirements of
 53.5 paragraph (c), each documentation of the provision of a service, unless otherwise specified,
 53.6 must include:

53.7 (1) the date the documentation occurred;

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

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

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

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

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

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

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

53.22 (b) A waiver transportation service provider must meet the documentation requirements
 53.23 under subdivision 12 and must maintain:

53.24 (1) odometer and other records as provided in section 256B.0625, subdivision 17b,
 53.25 paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle
 53.26 and driver for a waiver transportation service that is billed directly by the mile, except if
 53.27 the provider is a common carrier as defined by Minnesota Rules, part 9505.0315, subpart
 53.28 1, item B, or a publicly operated transit system; and

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

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

54.3 Subd. 14. **Equipment and supply documentation requirements.** (a) An equipment
54.4 and supply services provider must meet the documentation requirements under subdivision
54.5 12 and must, for each documentation of the provision of a service, include:

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

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

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

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

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

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

54.19 Subd. 15. **Adult day service documentation and billing requirements.** (a) A service
54.20 defined as "adult day care" under section 245A.02, subdivision 2a, and licensed under
54.21 Minnesota Rules, parts 9555.9600 to 9555.9730, must meet the documentation requirements
54.22 under subdivision 12 and must maintain documentation of:

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

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

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

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

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

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

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

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

55.12 **256B.5014 FINANCIAL REPORTING REQUIREMENTS.**

55.13 Subdivision 1. **Financial reporting.** All facilities shall maintain financial records and
 55.14 shall provide annual income and expense reports to the commissioner of human services
 55.15 on a form prescribed by the commissioner no later than April 30 of each year in order to
 55.16 receive medical assistance payments. The reports for the reporting year ending December
 55.17 31 must include:

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

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

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

55.25 (4) total annual resident days.

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

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

55.29 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
 55.30 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
 55.31 13a shall:

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

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

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

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

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

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

56.13 (7) meet the financial requirements established by the commissioner for financial
56.14 solvency;

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

56.19 (9) have an office located in Minnesota.

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

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

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

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

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

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

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

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

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

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

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

57.10 Sec. 54. **[256D.0245] DRUG TESTING INFORMATION FROM PROBATION**
 57.11 **OFFICERS.**

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

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

57.16 **256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.**

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

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

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

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

58.2 Subd. 47. **Income.** "Income" means cash or in-kind benefit, whether earned or unearned,
58.3 received by or available to an applicant or participant that is not property under section
58.4 256P.02. An applicant must document that the property is not available to the applicant.

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

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

58.8 (1) payments for basic care, difficulty of care, and clothing allowances received for
58.9 providing family foster care to children or adults under Minnesota Rules, parts 9555.5050
58.10 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0654, payments for family foster care for
58.11 children under section 260C.4411 or chapter 256N, and payments received and used for
58.12 care and maintenance of a third-party beneficiary who is not a household member;

58.13 (2) reimbursements for employment training received through the Workforce Investment
58.14 Act of 1998, United States Code, title 20, chapter 73, section 9201;

58.15 (3) reimbursement for out-of-pocket expenses incurred while performing volunteer
58.16 services, jury duty, employment, or informal carpooling arrangements directly related to
58.17 employment;

58.18 (4) all educational assistance, except the county agency must count graduate student
58.19 teaching assistantships, fellowships, and other similar paid work as earned income and,
58.20 after allowing deductions for any unmet and necessary educational expenses, shall count
58.21 scholarships or grants awarded to graduate students that do not require teaching or research
58.22 as unearned income;

58.23 (5) loans, regardless of purpose, from public or private lending institutions, governmental
58.24 lending institutions, or governmental agencies;

58.25 (6) loans from private individuals, regardless of purpose, provided an applicant or
58.26 participant ~~documents that the lender expects repayment~~ provides documentation of the
58.27 source of the loan, dates, amount of the loan, and terms of repayment;

58.28 (7)(i) state income tax refunds; and

58.29 (ii) federal income tax refunds;

58.30 (8)(i) federal earned income credits;

58.31 (ii) Minnesota working family credits;

- 59.1 (iii) state homeowners and renters credits under chapter 290A; and
- 59.2 (iv) federal or state tax rebates;
- 59.3 (9) funds received for reimbursement, replacement, or rebate of personal or real property
- 59.4 when these payments are made by public agencies, awarded by a court, solicited through
- 59.5 public appeal, or made as a grant by a federal agency, state or local government, or disaster
- 59.6 assistance organizations, subsequent to a presidential declaration of disaster;
- 59.7 (10) the portion of an insurance settlement that is used to pay medical, funeral, and burial
- 59.8 expenses, or to repair or replace insured property;
- 59.9 (11) reimbursements for medical expenses that cannot be paid by medical assistance;
- 59.10 (12) payments by a vocational rehabilitation program administered by the state under
- 59.11 chapter 268A, except those payments that are for current living expenses;
- 59.12 (13) in-kind income, including any payments directly made by a third party to a provider
- 59.13 of goods and services. In-kind income does not include in-kind payments of living expenses;
- 59.14 (14) assistance payments to correct underpayments, but only for the month in which the
- 59.15 payment is received;
- 59.16 (15) payments for short-term emergency needs under section 256J.626, subdivision 2;
- 59.17 (16) funeral and cemetery payments as provided by section 256.935;
- 59.18 (17) nonrecurring cash gifts of \$30 or less, not exceeding \$30 per participant in a calendar
- 59.19 month;
- 59.20 (18) any form of energy assistance payment made through Public Law 97-35,
- 59.21 Low-Income Home Energy Assistance Act of 1981, payments made directly to energy
- 59.22 providers by other public and private agencies, and any form of credit or rebate payment
- 59.23 issued by energy providers;
- 59.24 (19) Supplemental Security Income (SSI), including retroactive SSI payments and other
- 59.25 income of an SSI recipient;
- 59.26 (20) Minnesota supplemental aid, including retroactive payments;
- 59.27 (21) proceeds from the sale of real or personal property;
- 59.28 (22) adoption or kinship assistance payments under chapter 256N or 259A and Minnesota
- 59.29 permanency demonstration title IV-E waiver payments;
- 59.30 (23) state-funded family subsidy program payments made under section 252.32 to help
- 59.31 families care for children with developmental disabilities, consumer support grant funds

60.1 under section 256.476, and resources and services for a disabled household member under
60.2 one of the home and community-based waiver services programs under chapter 256B;

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

60.5 (25) rent rebates;

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

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

60.10 (28) MFIP child care payments under section 119B.05;

60.11 (29) all other payments made through MFIP to support a caregiver's pursuit of greater
60.12 economic stability;

60.13 (30) income a participant receives related to shared living expenses;

60.14 (31) reverse mortgages;

60.15 (32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42,
60.16 chapter 13A, sections 1771 to 1790;

60.17 (33) benefits provided by the women, infants, and children (WIC) nutrition program,
60.18 United States Code, title 42, chapter 13A, section 1786;

60.19 (34) benefits from the National School Lunch Act, United States Code, title 42, chapter
60.20 13, sections 1751 to 1769e;

60.21 (35) relocation assistance for displaced persons under the Uniform Relocation Assistance
60.22 and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter
60.23 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12,
60.24 chapter 13, sections 1701 to 1750jj;

60.25 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part
60.26 2, sections 2271 to 2322;

60.27 (37) war reparations payments to Japanese Americans and Aleuts under United States
60.28 Code, title 50, sections 1989 to 1989d;

60.29 (38) payments to veterans or their dependents as a result of legal settlements regarding
60.30 Agent Orange or other chemical exposure under Public Law 101-239, section 10405,
60.31 paragraph (a)(2)(E);

61.1 (39) income that is otherwise specifically excluded from MFIP consideration in federal
61.2 law, state law, or federal regulation;

61.3 (40) security and utility deposit refunds;

61.4 (41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124,
61.5 and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and
61.6 Mille Lacs reservations and payments to members of the White Earth Band, under United
61.7 States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

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

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

61.16 (44) payments made to children eligible for relative custody assistance under section
61.17 257.85;

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

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

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

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

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

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

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

62.1 Sec. 60. **[256J.265] DRUG TESTING INFORMATION FROM PROBATION**
 62.2 **OFFICERS.**

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

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

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

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

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

62.15 (1) identity of adults;

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

62.17 (3) immigration status;

62.18 (4) income;

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

62.20 (6) vehicles;

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

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

62.26 (9) residence;

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

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

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

63.3 (13) direct or indirect gifts of money.

63.4 (b) Applicants who are qualified noncitizens and victims of domestic violence as defined
 63.5 under section 256J.08, subdivision 73, clause (7), are not required to verify the information
 63.6 in paragraph (a), clause (10). When a Social Security number is not provided to the agency
 63.7 for verification, this requirement is satisfied when each member of the assistance unit
 63.8 cooperates with the procedures for verification of Social Security numbers, issuance of
 63.9 duplicate cards, and issuance of new numbers which have been established jointly between
 63.10 the Social Security Administration and the commissioner.

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

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

63.14 (1) earned income:

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

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

63.22 (2) unearned income, which includes:

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

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

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

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

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

63.29 (vi) cash prizes and winnings;

63.30 (vii) unemployment insurance income;

- 64.1 (viii) retirement, survivors, and disability insurance payments;
- 64.2 (ix) nonrecurring income over \$60 per quarter unless earmarked and used for the purpose
64.3 for which it is intended. Income and use of this income is subject to verification requirements
64.4 under section 256P.04;
- 64.5 (x) retirement benefits;
- 64.6 (xi) cash assistance benefits, as defined by each program in chapters 119B, 256D, 256I,
64.7 and 256J;
- 64.8 (xii) tribal per capita payments unless excluded by federal and state law;
- 64.9 (xiii) income and payments from service and rehabilitation programs that meet or exceed
64.10 the state's minimum wage rate;
- 64.11 (xiv) income from members of the United States armed forces unless excluded from
64.12 income taxes according to federal or state law;
- 64.13 (xv) all child support payments for programs under chapters 119B, 256D, and 256I;
- 64.14 (xvi) the amount of child support received that exceeds \$100 for assistance units with
64.15 one child and \$200 for assistance units with two or more children for programs under chapter
64.16 256J; and
- 64.17 (xvii) spousal support.

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

64.20 Sec. 49. ~~ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM~~
64.21 VISIT VERIFICATION.

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

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

65.1 (b) "~~Electronic service-delivery documentation~~ visit verification" means the electronic
65.2 documentation of the:

65.3 (1) type of service performed;

65.4 (2) individual receiving the service;

65.5 (3) date of the service;

65.6 (4) location of the service delivery;

65.7 (5) individual providing the service; and

65.8 (6) time the service begins and ends.

65.9 (c) "~~Electronic service-delivery documentation~~ visit verification system" means a system
65.10 that provides electronic ~~service-delivery documentation~~ verification of services that complies
65.11 with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision
65.12 3.

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

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

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

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

65.18 or

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

65.21 Subd. 3. **System requirements.** (a) In developing implementation requirements for an
65.22 ~~electronic service-delivery documentation system~~ visit verification, the commissioner shall
65.23 ~~consider electronic visit verification systems and other electronic service-delivery~~
65.24 ~~documentation methods. The commissioner shall convene stakeholders that will be impacted~~
65.25 ~~by an electronic service-delivery system, including service providers and their representatives,~~
65.26 ~~service recipients and their representatives, and, as appropriate, those with expertise in the~~
65.27 ~~development and operation of an electronic service-delivery documentation system, to ensure~~
65.28 that the requirements:

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

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

66.1 (3) consider existing best practices and use of electronic ~~service-delivery documentation~~
 66.2 visit verification;

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

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

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

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

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

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

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

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

66.21 (c) Providers must implement the electronic visit verification systems required under
 66.22 this section by January 1, 2020, for personal care services and by January 1, 2023, for home
 66.23 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
 66.24 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
 66.25 paragraph, "personal care services" and "home health services" have the meanings given
 66.26 in United States Code, title 42, section 1396b(1)(5). Reimbursement rates for providers must
 66.27 not be reduced as a result of federal action to reduce the federal medical assistance percentage
 66.28 under the 21st Century Cures Act, Public Law 114.255, Code of Federal Regulations, title
 66.29 32, section 310.32.

66.30 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,
 66.31 2018, to the chairs and ranking minority members of the legislative committees with
 66.32 jurisdiction over human services with recommendations, based on the requirements of

67.1 ~~subdivision 3, to establish electronic service delivery documentation system requirements~~
 67.2 ~~and standards. The report shall identify:~~

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

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

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

67.11 Sec. 65. **DIRECTIONS TO COMMISSIONER; NEMT DRIVER ENROLLMENT**
 67.12 **IMPACT.**

67.13 By August 1, 2021, the commissioner of human services shall issue a report to the chairs
 67.14 and ranking minority members of the house of representatives and senate committees with
 67.15 jurisdiction over health and human services. The commissioner must include in the report
 67.16 the commissioner's findings regarding the impact of driver enrollment under Minnesota
 67.17 Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the
 67.18 nonemergency medical transportation program. The commissioner must include a
 67.19 recommendation, based on the findings in the report, regarding expanding the driver
 67.20 enrollment requirement.

67.21 Sec. 66. **UNIVERSAL IDENTIFICATION NUMBER FOR CHILDREN IN EARLY**
 67.22 **CHILDHOOD PROGRAMS.**

67.23 By July 1, 2020, the commissioners of the Departments of Education, Health, and Human
 67.24 Services shall identify a process to establish and implement a universal identification number
 67.25 for children participating in early childhood programs to eliminate potential duplication in
 67.26 programs. The commissioners shall report the identified process and any associated fiscal
 67.27 cost to the chairs and ranking minority members of the legislative committees with
 67.28 jurisdiction over health, human services, and education. A universal identification number
 67.29 established and implemented under this section is private data on individuals, as defined in
 67.30 Minnesota Statutes, section 13.02, subdivision 12, except that the commissioners of
 67.31 education, health, and human services may share the universal identification number with
 67.32 each other pursuant to their data sharing authority under Minnesota Statutes, section 13.46,

68.1 subdivision 2, clause (9), and Minnesota Statutes, section 145A.17, subdivision 3, paragraph
 68.2 (e).

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

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

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

68.9 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
 68.10 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.

68.11 **Sec. 69. REPEALER.**

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

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

68.14 **ARTICLE 2**

68.15 **CHILDREN AND FAMILIES SERVICES**

68.16 Section 1. Minnesota Statutes 2018, section 13.46, subdivision 2, is amended to read:

68.17 Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated
 68.18 by the welfare system are private data on individuals, and shall not be disclosed except:

68.19 (1) according to section 13.05;

68.20 (2) according to court order;

68.21 (3) according to a statute specifically authorizing access to the private data;

68.22 (4) to an agent of the welfare system and an investigator acting on behalf of a county,
 68.23 the state, or the federal government, including a law enforcement person or attorney in the
 68.24 investigation or prosecution of a criminal, civil, or administrative proceeding relating to the
 68.25 administration of a program;

68.26 (5) to personnel of the welfare system who require the data to verify an individual's
 68.27 identity; determine eligibility, amount of assistance, and the need to provide services to an
 68.28 individual or family across programs; coordinate services for an individual or family;

69.1 evaluate the effectiveness of programs; assess parental contribution amounts; and investigate
69.2 suspected fraud;

69.3 (6) to administer federal funds or programs;

69.4 (7) between personnel of the welfare system working in the same program;

69.5 (8) to the Department of Revenue to assess parental contribution amounts for purposes
69.6 of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs
69.7 and to identify individuals who may benefit from these programs. The following information
69.8 may be disclosed under this paragraph: an individual's and their dependent's names, dates
69.9 of birth, Social Security numbers, income, addresses, and other data as required, upon
69.10 request by the Department of Revenue. Disclosures by the commissioner of revenue to the
69.11 commissioner of human services for the purposes described in this clause are governed by
69.12 section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited
69.13 to, the dependent care credit under section 290.067, the Minnesota working family credit
69.14 under section 290.0671, the property tax refund and rental credit under section 290A.04,
69.15 and the Minnesota education credit under section 290.0674;

69.16 (9) between the Department of Human Services, the Department of Employment and
69.17 Economic Development, and when applicable, the Department of Education, for the following
69.18 purposes:

69.19 (i) to monitor the eligibility of the data subject for unemployment benefits, for any
69.20 employment or training program administered, supervised, or certified by that agency;

69.21 (ii) to administer any rehabilitation program or child care assistance program, whether
69.22 alone or in conjunction with the welfare system;

69.23 (iii) to monitor and evaluate the Minnesota family investment program or the child care
69.24 assistance program by exchanging data on recipients and former recipients of food support,
69.25 cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter
69.26 119B, medical programs under chapter 256B or 256L, or a medical program formerly
69.27 codified under chapter 256D; and

69.28 (iv) to analyze public assistance employment services and program utilization, cost,
69.29 effectiveness, and outcomes as implemented under the authority established in Title II,
69.30 Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999.
69.31 Health records governed by sections 144.291 to 144.298 and "protected health information"
69.32 as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code

70.1 of Federal Regulations, title 45, parts 160-164, including health care claims utilization
70.2 information, must not be exchanged under this clause;

70.3 (10) to appropriate parties in connection with an emergency if knowledge of the
70.4 information is necessary to protect the health or safety of the individual or other individuals
70.5 or persons;

70.6 (11) data maintained by residential programs as defined in section 245A.02 may be
70.7 disclosed to the protection and advocacy system established in this state according to Part
70.8 C of Public Law 98-527 to protect the legal and human rights of persons with developmental
70.9 disabilities or other related conditions who live in residential facilities for these persons if
70.10 the protection and advocacy system receives a complaint by or on behalf of that person and
70.11 the person does not have a legal guardian or the state or a designee of the state is the legal
70.12 guardian of the person;

70.13 (12) to the county medical examiner or the county coroner for identifying or locating
70.14 relatives or friends of a deceased person;

70.15 (13) data on a child support obligor who makes payments to the public agency may be
70.16 disclosed to the Minnesota Office of Higher Education to the extent necessary to determine
70.17 eligibility under section 136A.121, subdivision 2, clause (5);

70.18 (14) participant Social Security numbers and names collected by the telephone assistance
70.19 program may be disclosed to the Department of Revenue to conduct an electronic data
70.20 match with the property tax refund database to determine eligibility under section 237.70,
70.21 subdivision 4a;

70.22 (15) the current address of a Minnesota family investment program participant may be
70.23 disclosed to law enforcement officers who provide the name of the participant and notify
70.24 the agency that:

70.25 (i) the participant:

70.26 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after
70.27 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the
70.28 jurisdiction from which the individual is fleeing; or

70.29 (B) is violating a condition of probation or parole imposed under state or federal law;

70.30 (ii) the location or apprehension of the felon is within the law enforcement officer's
70.31 official duties; and

70.32 (iii) the request is made in writing and in the proper exercise of those duties;

71.1 (16) the current address of a recipient of general assistance may be disclosed to probation
71.2 officers and corrections agents who are supervising the recipient and to law enforcement
71.3 officers who are investigating the recipient in connection with a felony level offense;

71.4 (17) information obtained from food support applicant or recipient households may be
71.5 disclosed to local, state, or federal law enforcement officials, upon their written request, for
71.6 the purpose of investigating an alleged violation of the Food Stamp Act, according to Code
71.7 of Federal Regulations, title 7, section 272.1(c);

71.8 (18) the address, Social Security number, and, if available, photograph of any member
71.9 of a household receiving food support shall be made available, on request, to a local, state,
71.10 or federal law enforcement officer if the officer furnishes the agency with the name of the
71.11 member and notifies the agency that:

71.12 (i) the member:

71.13 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a
71.14 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

71.15 (B) is violating a condition of probation or parole imposed under state or federal law;
71.16 or

71.17 (C) has information that is necessary for the officer to conduct an official duty related
71.18 to conduct described in subitem (A) or (B);

71.19 (ii) locating or apprehending the member is within the officer's official duties; and

71.20 (iii) the request is made in writing and in the proper exercise of the officer's official duty;

71.21 (19) the current address of a recipient of Minnesota family investment program, general
71.22 assistance, or food support may be disclosed to law enforcement officers who, in writing,
71.23 provide the name of the recipient and notify the agency that the recipient is a person required
71.24 to register under section 243.166, but is not residing at the address at which the recipient is
71.25 registered under section 243.166;

71.26 (20) certain information regarding child support obligors who are in arrears may be
71.27 made public according to section 518A.74;

71.28 (21) data on child support payments made by a child support obligor and data on the
71.29 distribution of those payments excluding identifying information on obligees may be
71.30 disclosed to all obligees to whom the obligor owes support, and data on the enforcement
71.31 actions undertaken by the public authority, the status of those actions, and data on the income
71.32 of the obligor or obligee may be disclosed to the other party;

72.1 (22) data in the work reporting system may be disclosed under section 256.998,
72.2 subdivision 7;

72.3 (23) to the Department of Education for the purpose of matching Department of Education
72.4 student data with public assistance data to determine students eligible for free and
72.5 reduced-price meals, meal supplements, and free milk according to United States Code,
72.6 title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state
72.7 funds that are distributed based on income of the student's family; and to verify receipt of
72.8 energy assistance for the telephone assistance plan;

72.9 (24) the current address and telephone number of program recipients and emergency
72.10 contacts may be released to the commissioner of health or a community health board as
72.11 defined in section 145A.02, subdivision 5, when the commissioner or community health
72.12 board has reason to believe that a program recipient is a disease case, carrier, suspect case,
72.13 or at risk of illness, and the data are necessary to locate the person;

72.14 (25) to other state agencies, statewide systems, and political subdivisions of this state,
72.15 including the attorney general, and agencies of other states, interstate information networks,
72.16 federal agencies, and other entities as required by federal regulation or law for the
72.17 administration of the child support enforcement program;

72.18 (26) to personnel of public assistance programs as defined in section 256.741, for access
72.19 to the child support system database for the purpose of administration, including monitoring
72.20 and evaluation of those public assistance programs;

72.21 (27) to monitor and evaluate the Minnesota family investment program by exchanging
72.22 data between the Departments of Human Services and Education, on recipients and former
72.23 recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child
72.24 care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a
72.25 medical program formerly codified under chapter 256D;

72.26 (28) to evaluate child support program performance and to identify and prevent fraud
72.27 in the child support program by exchanging data between the Department of Human Services,
72.28 Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b),
72.29 without regard to the limitation of use in paragraph (c), Department of Health, Department
72.30 of Employment and Economic Development, and other state agencies as is reasonably
72.31 necessary to perform these functions;

72.32 (29) counties and the Department of Human Services operating child care assistance
72.33 programs under chapter 119B may disseminate data on program participants, applicants,
72.34 and providers to the commissioner of education;

73.1 (30) child support data on the child, the parents, and relatives of the child may be
 73.2 disclosed to agencies administering programs under titles IV-B and IV-E of the Social
 73.3 Security Act, as authorized by federal law;

73.4 (31) to a health care provider governed by sections 144.291 to 144.298, to the extent
 73.5 necessary to coordinate services;

73.6 (32) to the chief administrative officer of a school to coordinate services for a student
 73.7 and family; data that may be disclosed under this clause are limited to name, date of birth,
 73.8 gender, and address; or

73.9 (33) to county correctional agencies to the extent necessary to coordinate services and
 73.10 diversion programs; data that may be disclosed under this clause are limited to name, client
 73.11 demographics, program, case status, and county worker information.

73.12 (b) Information on persons who have been treated for drug or alcohol abuse may only
 73.13 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
 73.14 2.1 to 2.67.

73.15 (c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16),
 73.16 (17), or (18), or paragraph (b), are investigative data and are confidential or protected
 73.17 nonpublic while the investigation is active. The data are private after the investigation
 73.18 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

73.19 (d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are
 73.20 not subject to the access provisions of subdivision 10, paragraph (b).

73.21 For the purposes of this subdivision, a request will be deemed to be made in writing if
 73.22 made through a computer interface system.

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

73.24 Sec. 2. Minnesota Statutes 2018, section 13.46, subdivision 4, is amended to read:

73.25 Subd. 4. **Licensing data.** (a) As used in this subdivision:

73.26 (1) "licensing data" are all data collected, maintained, used, or disseminated by the
 73.27 welfare system pertaining to persons licensed or registered or who apply for licensure or
 73.28 registration or who formerly were licensed or registered under the authority of the
 73.29 commissioner of human services;

73.30 (2) "client" means a person who is receiving services from a licensee or from an applicant
 73.31 for licensure; and

74.1 (3) "personal and personal financial data" are Social Security numbers, identity of and
74.2 letters of reference, insurance information, reports from the Bureau of Criminal
74.3 Apprehension, health examination reports, and social/home studies.

74.4 (b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license
74.5 holders, and former licensees are public: name, address, telephone number of licensees,
74.6 date of receipt of a completed application, dates of licensure, licensed capacity, type of
74.7 client preferred, variances granted, record of training and education in child care and child
74.8 development, type of dwelling, name and relationship of other family members, previous
74.9 license history, class of license, the existence and status of complaints, and the number of
74.10 serious injuries to or deaths of individuals in the licensed program as reported to the
74.11 commissioner of human services, the local social services agency, or any other county
74.12 welfare agency. For purposes of this clause, a serious injury is one that is treated by a
74.13 physician.

74.14 (ii) Except as provided in item (v), when a correction order, an order to forfeit a fine,
74.15 an order of license suspension, an order of temporary immediate suspension, an order of
74.16 license revocation, an order of license denial, or an order of conditional license has been
74.17 issued, or a complaint is resolved, the following data on current and former licensees and
74.18 applicants are public: the general nature of the complaint or allegations leading to the
74.19 temporary immediate suspension; the substance and investigative findings of the licensing
74.20 or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence
74.21 of settlement negotiations; the record of informal resolution of a licensing violation; orders
74.22 of hearing; findings of fact; conclusions of law; specifications of the final correction order,
74.23 fine, suspension, temporary immediate suspension, revocation, denial, or conditional license
74.24 contained in the record of licensing action; whether a fine has been paid; and the status of
74.25 any appeal of these actions.

74.26 (iii) When a license denial under section 245A.05 or a sanction under section 245A.07
74.27 is based on a determination that a license holder, applicant, or controlling individual is
74.28 responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant,
74.29 license holder, or controlling individual as the individual responsible for maltreatment is
74.30 public data at the time of the issuance of the license denial or sanction.

74.31 (iv) When a license denial under section 245A.05 or a sanction under section 245A.07
74.32 is based on a determination that a license holder, applicant, or controlling individual is
74.33 disqualified under chapter 245C, the identity of the license holder, applicant, or controlling
74.34 individual as the disqualified individual and the reason for the disqualification are public
74.35 data at the time of the issuance of the licensing sanction or denial. If the applicant, license

75.1 holder, or controlling individual requests reconsideration of the disqualification and the
75.2 disqualification is affirmed, the reason for the disqualification and the reason to not set aside
75.3 the disqualification are public data.

75.4 (v) A correction order or fine issued to a child care provider for a licensing violation is
75.5 private data on individuals under section 13.02, subdivision 12, or nonpublic data under
75.6 section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

75.7 (2) For applicants who withdraw their application prior to licensure or denial of a license,
75.8 the following data are public: the name of the applicant, the city and county in which the
75.9 applicant was seeking licensure, the dates of the commissioner's receipt of the initial
75.10 application and completed application, the type of license sought, and the date of withdrawal
75.11 of the application.

75.12 (3) For applicants who are denied a license, the following data are public: the name and
75.13 address of the applicant, the city and county in which the applicant was seeking licensure,
75.14 the dates of the commissioner's receipt of the initial application and completed application,
75.15 the type of license sought, the date of denial of the application, the nature of the basis for
75.16 the denial, the existence of settlement negotiations, the record of informal resolution of a
75.17 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final
75.18 order of denial, and the status of any appeal of the denial.

75.19 (4) When maltreatment is substantiated under section 626.556 or 626.557 and the victim
75.20 and the substantiated perpetrator are affiliated with a program licensed under chapter 245A,
75.21 the commissioner of human services, local social services agency, or county welfare agency
75.22 may inform the license holder where the maltreatment occurred of the identity of the
75.23 substantiated perpetrator and the victim.

75.24 (5) Notwithstanding clause (1), for child foster care, only the name of the license holder
75.25 and the status of the license are public if the county attorney has requested that data otherwise
75.26 classified as public data under clause (1) be considered private data based on the best interests
75.27 of a child in placement in a licensed program.

75.28 (c) The following are private data on individuals under section 13.02, subdivision 12,
75.29 or nonpublic data under section 13.02, subdivision 9: personal and personal financial data
75.30 on family day care program and family foster care program applicants and licensees and
75.31 their family members who provide services under the license.

75.32 (d) The following are private data on individuals: the identity of persons who have made
75.33 reports concerning licensees or applicants that appear in inactive investigative data, and the
75.34 records of clients or employees of the licensee or applicant for licensure whose records are

76.1 received by the licensing agency for purposes of review or in anticipation of a contested
76.2 matter. The names of reporters of complaints or alleged violations of licensing standards
76.3 under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment
76.4 under sections 626.556 and 626.557, are confidential data and may be disclosed only as
76.5 provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

76.6 (e) Data classified as private, confidential, nonpublic, or protected nonpublic under this
76.7 subdivision become public data if submitted to a court or administrative law judge as part
76.8 of a disciplinary proceeding in which there is a public hearing concerning a license which
76.9 has been suspended, immediately suspended, revoked, or denied.

76.10 (f) Data generated in the course of licensing investigations that relate to an alleged
76.11 violation of law are investigative data under subdivision 3.

76.12 (g) Data that are not public data collected, maintained, used, or disseminated under this
76.13 subdivision that relate to or are derived from a report as defined in section 626.556,
76.14 subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of
76.15 sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

76.16 (h) Upon request, not public data collected, maintained, used, or disseminated under
76.17 this subdivision that relate to or are derived from a report of substantiated maltreatment as
76.18 defined in section 626.556 or 626.557 may be exchanged with the Department of Health
76.19 for purposes of completing background studies pursuant to section 144.057 and with the
76.20 Department of Corrections for purposes of completing background studies pursuant to
76.21 section 241.021.

76.22 (i) Data on individuals collected according to licensing activities under chapters 245A
76.23 and 245C, data on individuals collected by the commissioner of human services according
76.24 to investigations under chapters 245A, 245B, 245C, and 245D, and sections 626.556 and
76.25 626.557 may be shared with the Department of Human Rights, the Department of Health,
76.26 the Department of Corrections, the ombudsman for mental health and developmental
76.27 disabilities, and the individual's professional regulatory board when there is reason to believe
76.28 that laws or standards under the jurisdiction of those agencies may have been violated or
76.29 the information may otherwise be relevant to the board's regulatory jurisdiction. Background
76.30 study data on an individual who is the subject of a background study under chapter 245C
76.31 for a licensed service for which the commissioner of human services is the license holder
76.32 may be shared with the commissioner and the commissioner's delegate by the licensing
76.33 division. Unless otherwise specified in this chapter, the identity of a reporter of alleged
76.34 maltreatment or licensing violations may not be disclosed.

77.1 (j) In addition to the notice of determinations required under section 626.556, subdivision
 77.2 10f, if the commissioner or the local social services agency has determined that an individual
 77.3 is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined
 77.4 in section 626.556, subdivision 2, and the commissioner or local social services agency
 77.5 knows that the individual is a person responsible for a child's care in another facility, the
 77.6 commissioner or local social services agency shall notify the head of that facility of this
 77.7 determination. The notification must include an explanation of the individual's available
 77.8 appeal rights and the status of any appeal. If a notice is given under this paragraph, the
 77.9 government entity making the notification shall provide a copy of the notice to the individual
 77.10 who is the subject of the notice.

77.11 (k) All not public data collected, maintained, used, or disseminated under this subdivision
 77.12 and subdivision 3 may be exchanged between the Department of Human Services, Licensing
 77.13 Division, and the Department of Corrections for purposes of regulating services for which
 77.14 the Department of Human Services and the Department of Corrections have regulatory
 77.15 authority.

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

77.17 Sec. 3. Minnesota Statutes 2018, section 13.461, subdivision 28, is amended to read:

77.18 Subd. 28. **Child care assistance program.** (a) Data collected, maintained, used, or
 77.19 disseminated by the welfare system pertaining to persons selected as legal nonlicensed child
 77.20 care providers by families receiving child care assistance are classified under section 119B.02,
 77.21 subdivision 6, paragraph (a). Child care assistance program payment data is classified under
 77.22 section 119B.02, subdivision 6, paragraph (b).

77.23 (b) Data relating to child care assistance program disqualification is governed by section
 77.24 124D.165, subdivision 4a.

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

77.26 Sec. 4. Minnesota Statutes 2018, section 119B.02, subdivision 6, is amended to read:

77.27 Subd. 6. **Data.** (a) Data collected, maintained, used, or disseminated by the welfare
 77.28 system pertaining to persons selected as legal nonlicensed child care providers by families
 77.29 receiving child care assistance shall be treated as licensing data as provided in section 13.46,
 77.30 subdivision 4.

77.31 (b) For purposes of this paragraph, "child care assistance program payment data" means
 77.32 data for a specified time period showing (1) that a child care assistance program payment

78.1 under this chapter was made, and (2) the amount of child care assistance payments made
 78.2 to a child care center. Child care assistance program payment data may include the number
 78.3 of families and children on whose behalf payments were made for the specified time period.
 78.4 Any child care assistance program payment data that may identify a specific child care
 78.5 assistance recipient or benefit paid on behalf of a specific child care assistance recipient,
 78.6 as determined by the commissioner, is private data on individuals as defined in section
 78.7 13.02, subdivision 12. Data related to a child care assistance payment is public if the data
 78.8 relates to a child care assistance payment made to a licensed child care center or a child
 78.9 care center exempt from licensure and:

78.10 (1) the child care center receives payment of more than \$100,000 from the child care
 78.11 assistance program under this chapter in a period of one year or less; or

78.12 (2) when the commissioner or county agency either:

78.13 (i) disqualified the center from receipt of a payment from the child care assistance
 78.14 program under this chapter for wrongfully obtaining child care assistance under section
 78.15 256.98, subdivision 8, paragraph (c);

78.16 (ii) refused a child care authorization, revoked a child care authorization, stopped
 78.17 payment, or denied payment for a bill for the center under section 119B.13, subdivision 6,
 78.18 paragraph (d); or

78.19 (iii) made a finding of financial misconduct under section 245E.02.

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

78.21 Sec. 5. Minnesota Statutes 2018, section 245A.03, subdivision 2, is amended to read:

78.22 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

78.23 (1) residential or nonresidential programs that are provided to a person by an individual
 78.24 who is related unless the residential program is a child foster care placement made by a
 78.25 local social services agency or a licensed child-placing agency, except as provided in
 78.26 subdivision 2a;

78.27 (2) nonresidential programs that are provided by an unrelated individual to persons from
 78.28 a single related family;

78.29 (3) residential or nonresidential programs that are provided to adults who do not misuse
 78.30 substances or have a substance use disorder, a mental illness, a developmental disability, a
 78.31 functional impairment, or a physical disability;

- 79.1 (4) sheltered workshops or work activity programs that are certified by the commissioner
79.2 of employment and economic development;
- 79.3 (5) programs operated by a public school for children 33 months or older;
- 79.4 (6) nonresidential programs primarily for children that provide care or supervision for
79.5 periods of less than three hours a day while the child's parent or legal guardian is in the
79.6 same building as the nonresidential program or present within another building that is
79.7 directly contiguous to the building in which the nonresidential program is located;
- 79.8 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
79.9 under section 245A.02;
- 79.10 (8) board and lodge facilities licensed by the commissioner of health that do not provide
79.11 children's residential services under Minnesota Rules, chapter 2960, mental health or chemical
79.12 dependency treatment;
- 79.13 (9) homes providing programs for persons placed by a county or a licensed agency for
79.14 legal adoption, unless the adoption is not completed within two years;
- 79.15 (10) programs licensed by the commissioner of corrections;
- 79.16 (11) recreation programs for children or adults that are operated or approved by a park
79.17 and recreation board whose primary purpose is to provide social and recreational activities;
- 79.18 (12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA
79.19 as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in
79.20 section 315.51, whose primary purpose is to provide child care or services to school-age
79.21 children;
- 79.22 (13) Head Start nonresidential programs which operate for less than 45 days in each
79.23 calendar year;
- 79.24 (14) noncertified boarding care homes unless they provide services for five or more
79.25 persons whose primary diagnosis is mental illness or a developmental disability;
- 79.26 (15) programs for children such as scouting, boys clubs, girls clubs, and sports and art
79.27 programs, and nonresidential programs for children provided for a cumulative total of less
79.28 than 30 days in any 12-month period;
- 79.29 (16) residential programs for persons with mental illness, that are located in hospitals;
- 79.30 (17) the religious instruction of school-age children; Sabbath or Sunday schools; or the
79.31 congregate care of children by a church, congregation, or religious society during the period
79.32 used by the church, congregation, or religious society for its regular worship;

80.1 (18) camps licensed by the commissioner of health under Minnesota Rules, chapter
80.2 4630;

80.3 (19) mental health outpatient services for adults with mental illness or children with
80.4 emotional disturbance;

80.5 (20) residential programs serving school-age children whose sole purpose is cultural or
80.6 educational exchange, until the commissioner adopts appropriate rules;

80.7 (21) community support services programs as defined in section 245.462, subdivision
80.8 6, and family community support services as defined in section 245.4871, subdivision 17;

80.9 (22) the placement of a child by a birth parent or legal guardian in a preadoptive home
80.10 for purposes of adoption as authorized by section 259.47;

80.11 (23) settings registered under chapter 144D which provide home care services licensed
80.12 by the commissioner of health to fewer than seven adults;

80.13 (24) substance use disorder treatment activities of licensed professionals in private
80.14 practice as defined in section 245G.01, subdivision 17;

80.15 (25) consumer-directed community support service funded under the Medicaid waiver
80.16 for persons with developmental disabilities when the individual who provided the service
80.17 is:

80.18 (i) the same individual who is the direct payee of these specific waiver funds or paid by
80.19 a fiscal agent, fiscal intermediary, or employer of record; and

80.20 (ii) not otherwise under the control of a residential or nonresidential program that is
80.21 required to be licensed under this chapter when providing the service;

80.22 (26) a program serving only children who are age 33 months or older, that is operated
80.23 by a nonpublic school, for no more than four hours per day per child, with no more than 20
80.24 children at any one time, and that is accredited by:

80.25 (i) an accrediting agency that is formally recognized by the commissioner of education
80.26 as a nonpublic school accrediting organization; or

80.27 (ii) an accrediting agency that requires background studies and that receives and
80.28 investigates complaints about the services provided.

80.29 A program that asserts its exemption from licensure under item (ii) shall, upon request
80.30 from the commissioner, provide the commissioner with documentation from the accrediting
80.31 agency that verifies: that the accreditation is current; that the accrediting agency investigates

81.1 complaints about services; and that the accrediting agency's standards require background
81.2 studies on all people providing direct contact services;

81.3 (27) a program operated by a nonprofit organization incorporated in Minnesota or another
81.4 state that serves youth in kindergarten through grade 12; provides structured, supervised
81.5 youth development activities; and has learning opportunities take place before or after
81.6 school, on weekends, or during the summer or other seasonal breaks in the school calendar.
81.7 A program exempt under this clause is not eligible for child care assistance under chapter
81.8 119B. A program exempt under this clause must:

81.9 (i) have a director or supervisor on site who is responsible for overseeing written policies
81.10 relating to the management and control of the daily activities of the program, ensuring the
81.11 health and safety of program participants, and supervising staff and volunteers;

81.12 (ii) have obtained written consent from a parent or legal guardian for each youth
81.13 participating in activities at the site; and

81.14 (iii) have provided written notice to a parent or legal guardian for each youth at the site
81.15 that the program is not licensed or supervised by the state of Minnesota and is not eligible
81.16 to receive child care assistance payments;

81.17 (28) a county that is an eligible vendor under section 254B.05 to provide care coordination
81.18 and comprehensive assessment services; ~~or~~

81.19 (29) a recovery community organization that is an eligible vendor under section 254B.05
81.20 to provide peer recovery support services; or

81.21 (30) family child care that is provided by an unrelated individual to families that do not
81.22 receive child care assistance if the number of children served does not exceed six children,
81.23 of which there are no more than a combined total of two infants and toddlers that includes
81.24 no more than one infant.

81.25 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
81.26 building in which a nonresidential program is located if it shares a common wall with the
81.27 building in which the nonresidential program is located or is attached to that building by
81.28 skyway, tunnel, atrium, or common roof.

81.29 (c) Except for the home and community-based services identified in section 245D.03,
81.30 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
81.31 provided and funded according to an approved federal waiver plan where licensure is
81.32 specifically identified as not being a condition for the services and funding.

82.1 Sec. 6. Minnesota Statutes 2018, section 245A.04, subdivision 4, is amended to read:

82.2 Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, the commissioner
82.3 shall conduct an inspection of the program. The inspection must include but is not limited
82.4 to:

82.5 (1) an inspection of the physical plant;

82.6 (2) an inspection of records and documents;

82.7 (3) an evaluation of the program by consumers of the program;

82.8 (4) observation of the program in operation; and

82.9 (5) an inspection for the health, safety, and fire standards in licensing requirements for
82.10 a child care license holder.

82.11 For the purposes of this subdivision, "consumer" means a person who receives the
82.12 services of a licensed program, the person's legal guardian, or the parent or individual having
82.13 legal custody of a child who receives the services of a licensed program.

82.14 (b) The evaluation required in paragraph (a), clause (3), or the observation in paragraph
82.15 (a), clause (4), is not required prior to issuing an initial license under subdivision 7. If the
82.16 commissioner issues an initial license under subdivision 7, these requirements must be
82.17 completed within one year after the issuance of an initial license.

82.18 (c) Before completing a licensing inspection in a family child care program or child care
82.19 center, the licensing agency must offer the license holder an exit interview to discuss all
82.20 violations of law or rule observed during the inspection and offer technical assistance on
82.21 how to comply with applicable laws and rules. The commissioner shall not issue a correction
82.22 order or negative action for violations of law or rule not discussed in an exit interview.
82.23 Nothing in this paragraph limits the ability of the commissioner to issue a correction order
82.24 or negative action for violations of law or rule ~~not discussed in an exit interview~~ or in the
82.25 event that a license holder chooses not to participate in an exit interview.

82.26 (d) The commissioner or the county shall inspect at least annually a child care provider
82.27 licensed under this chapter and Minnesota Rules, chapter 9502 or 9503, for compliance
82.28 with applicable licensing standards. Inspections of family child care providers shall be
82.29 conducted in accordance with section 245A.055. It shall not constitute a violation of rule
82.30 or statute for an individual who is related to a licensed family child care provider as defined
82.31 in section 245A.02, subdivision 13, to be present in the residence during business hours,
82.32 unless the individual provides sufficient hours or days of child care services for statutory

83.1 training requirements to apply, or the spouse is designated to be a caregiver, helper, or
 83.2 substitute in the family child care program.

83.3 (e) ~~No later than November 19, 2017,~~ The commissioner shall make publicly available
 83.4 on the department's website the results of inspection reports of all child care providers
 83.5 licensed under this chapter and under Minnesota Rules, chapter 9502 or 9503, and the
 83.6 number of deaths, serious injuries, and instances of substantiated child maltreatment that
 83.7 occurred in licensed child care settings each year. The results of inspection reports shall not
 83.8 be displayed on the department's website for longer than the minimum required time under
 83.9 federal law.

83.10 **EFFECTIVE DATE.** This section is effective the day following final enactment, with
 83.11 the exception that the amendments to paragraph (e) are effective August 1, 2019, and the
 83.12 requirement for inspections of family child care centers to be conducted in accordance with
 83.13 section 245A.055 is effective July 1, 2020.

83.14 Sec. 7. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to
 83.15 read:

83.16 **Subd. 18. Plain-language handbook.** By January 1, 2020, the commissioner of human
 83.17 services shall, following consultation with family child care license holders, parents, and
 83.18 county agencies, develop a plain-language handbook that describes the process and
 83.19 requirements to become a licensed family child care provider. The handbook shall include
 83.20 a list of the applicable statutory provisions and rules that apply to licensed family child care
 83.21 providers. The commissioner shall electronically publish the handbook on the Department
 83.22 of Human Services website, available at no charge to the public. Each county human services
 83.23 office and the Department of Human Services shall maintain physical copies of the handbook
 83.24 for public use.

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

83.26 Sec. 8. **[245A.055] FAMILY CHILD CARE PROVIDER INSPECTIONS.**

83.27 **Subdivision 1. Inspections.** The commissioner shall conduct inspections of each family
 83.28 child care provider pursuant to section 245A.04, subdivision 4, paragraph (d).

83.29 **Subd. 2. Types of child care licensing inspections.** (a) "Initial inspection" means an
 83.30 inspection before issuing an initial license under section 245A.04, subdivision 4, paragraph
 83.31 (a).

84.1 (b) "Full inspection" means the inspection of a family child care provider to determine
84.2 ongoing compliance with all applicable legal requirements for family child care providers.
84.3 A full inspection shall be conducted for temporary provisional licensees and for providers
84.4 who do not meet the requirements needed for an abbreviated inspection.

84.5 (c) "Abbreviated inspection" means the inspection of a family child care provider to
84.6 determine ongoing compliance with key indicators that statistically predict compliance with
84.7 all applicable legal requirements for family child care providers. Abbreviated inspections
84.8 are available for family child care providers who have been licensed for at least three years
84.9 with the latest inspection finding no Level 4 violations. Providers must also not have had
84.10 any substantiated licensing complaints that amount to a Level 4 violation, substantiated
84.11 complaints of maltreatment, or sanctions under section 245A.07 in the past three years. If
84.12 a county licenser finds that the provider has failed to comply with any key indicator during
84.13 an abbreviated inspection, the county licenser shall immediately conduct a full inspection.

84.14 (d) "Follow-up inspection" means a full inspection conducted following an inspection
84.15 that found more than one Level 4 violation.

84.16 Subd. 3. **Enforcement actions.** (a) Except where required by federal law, enforcement
84.17 actions under this subdivision may be taken based on the risk level of the violation as follows:

84.18 (1) Level 1: a violation that presents no risk of harm or minimal risk of harm, warranting
84.19 verbal technical assistance under section 245A.066, subdivision 1;

84.20 (2) Level 2: a violation that presents a low risk of harm, warranting issuance of a technical
84.21 assistance notice under section 245A.066, subdivision 2;

84.22 (3) Level 3: a violation that presents a moderate risk of harm, warranting issuance of a
84.23 fix-it ticket under section 245A.065; and

84.24 (4) Level 4: a violation that presents a substantial risk of harm, warranting issuance of
84.25 a correction order or conditional license under section 245A.06.

84.26 (b) The commissioner shall, following consultation with family child care license holders,
84.27 parents, and county agencies, issue a report by January 1, 2020, that identifies the violations
84.28 of this chapter and Minnesota Rules, chapter 9502, that constitute Level 1, Level 2, Level
84.29 3, or Level 4 violations based on the schedule in paragraph (a). The commissioner shall
84.30 also identify the rules and statutes that may be violated at more than one risk level, such
84.31 that the county licenser may assign the violation a risk level according to the licenser's
84.32 discretion during an inspection. The report shall also identify all rules and statutory provisions
84.33 that must be enforced in accordance with federal law. The commissioner shall provide the

85.1 report to county agencies and the chairs and ranking minority members of the legislative
 85.2 committees with jurisdiction over child care, and shall post the report to the department's
 85.3 website. By July 1, 2020, the commissioner shall develop, distribute, and provide training
 85.4 on guidelines on the use of the risk-based violation levels in paragraph (a) during family
 85.5 child care provider inspections.

85.6 Subd. 4. **Follow-up inspections.** If, upon inspection, the commissioner finds more than
 85.7 one Level 4 violation, the commissioner shall conduct a follow-up inspection within six
 85.8 months. The date of the follow-up inspection does not alter the provider's annual inspection
 85.9 date.

85.10 **EFFECTIVE DATE.** This section is effective July 1, 2020, with the exception that
 85.11 subdivision 3, paragraph (b), is effective the day following final enactment.

85.12 Sec. 9. Minnesota Statutes 2018, section 245A.06, subdivision 1, is amended to read:

85.13 Subdivision 1. **Contents of correction orders and conditional licenses.** (a) Except as
 85.14 provided in paragraph (c), if the commissioner finds that the applicant or license holder has
 85.15 failed to comply with an applicable law or rule and this failure does not imminently endanger
 85.16 the health, safety, or rights of the persons served by the program, the commissioner may
 85.17 issue a correction order and an order of conditional license to the applicant or license holder.
 85.18 When issuing a conditional license, the commissioner shall consider the nature, chronicity,
 85.19 or severity of the violation of law or rule and the effect of the violation on the health, safety,
 85.20 or rights of persons served by the program. The correction order or conditional license must
 85.21 state the following in plain language:

85.22 (1) the conditions that constitute a violation of the law or rule;

85.23 (2) the specific law or rule violated;

85.24 (3) the time allowed to correct each violation; and

85.25 (4) if a license is made conditional, the length and terms of the conditional license, and
 85.26 the reasons for making the license conditional.

85.27 (b) Nothing in this section prohibits the commissioner from proposing a sanction as
 85.28 specified in section 245A.07, prior to issuing a correction order or conditional license.

85.29 (c) For family child care license holders, the commissioner may issue a correction order
 85.30 or conditional license as provided in this section if, upon inspection, the commissioner finds
 85.31 a Level 4 violation as provided in section 245A.055, subdivision 3, or if a child care provider
 85.32 fails to correct a Level 3 violation as required under section 245A.065, paragraph (e).

86.1 **EFFECTIVE DATE.** This section is effective July 1, 2020.

86.2 Sec. 10. Minnesota Statutes 2018, section 245A.06, is amended by adding a subdivision
86.3 to read:

86.4 **Subd. 10. Licensing interpretation disputes.** When a county licenser and child care
86.5 provider dispute the interpretation of a licensing requirement, a county licenser must seek
86.6 clarification from the Department of Human Services in writing before issuing a correction
86.7 order related to the disputed interpretation. The license holder must be included in all
86.8 correspondence between the county and the Department of Human Services regarding the
86.9 dispute. The provider must be given the opportunity to contribute pertinent information that
86.10 may impact the decision by the Department of Human Services.

86.11 Sec. 11. Minnesota Statutes 2018, section 245A.065, is amended to read:

86.12 **245A.065 CHILD CARE FIX-IT TICKET.**

86.13 **Subdivision 1. Contents of fix-it tickets.** (a) ~~In lieu of a correction order under section~~
86.14 ~~245A.06,~~ The commissioner ~~shall~~ may issue a fix-it ticket to a family child care or child
86.15 care center license holder if, upon inspection, the commissioner finds that:

86.16 (1) the license holder has failed to comply with a requirement in this chapter or Minnesota
86.17 Rules, chapter 9502 or 9503, ~~that the commissioner determines to be eligible for a fix-it~~
86.18 ~~ticket;~~

86.19 (2) the violation does not imminently endanger the health, safety, or rights of the persons
86.20 served by the program;

86.21 (3) the license holder did not receive a fix-it ticket or correction order for the violation
86.22 at the license holder's last licensing inspection; and

86.23 (4) the violation ~~can~~ cannot be corrected at the time of inspection ~~or within 48 hours,~~
86.24 ~~excluding Saturdays, Sundays, and holidays; and~~

86.25 (5) ~~the license holder corrects the violation at the time of inspection or agrees to correct~~
86.26 ~~the violation within 48 hours, excluding Saturdays, Sundays, and holidays.~~

86.27 (b) The commissioner shall not issue a fix-it ticket for violations that are corrected at
86.28 the time of the inspection.

86.29 (c) The fix-it ticket must state:

86.30 (1) the conditions that constitute a violation of the law or rule;

87.1 (2) the specific law or rule violated; and

87.2 (3) that the violation ~~was corrected at the time of inspection or~~ must be corrected within
87.3 48 hours, excluding Saturdays, Sundays, and holidays.

87.4 ~~(e)~~ (d) The commissioner shall not publicly publish a fix-it ticket on the department's
87.5 website, unless required by federal law.

87.6 ~~(d)~~ (e) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it
87.7 ticket, the license holder must correct the violation and within one week submit evidence
87.8 to the licensing agency that the violation was corrected.

87.9 ~~(e)~~ (f) If the violation is not corrected ~~at the time of inspection or~~ within 48 hours,
87.10 excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to
87.11 establish that the license holder corrected the violation, the commissioner ~~must~~ may issue
87.12 a correction order, according to section 245A.06, for the violation of Minnesota law or rule
87.13 identified in the fix-it ticket ~~according to section 245A.06.~~

87.14 ~~(f) The commissioner shall, following consultation with family child care license holders,~~
87.15 ~~child care center license holders, and county agencies, issue a report by October 1, 2017,~~
87.16 ~~that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503,~~
87.17 ~~that are eligible for a fix-it ticket. The commissioner shall provide the report to county~~
87.18 ~~agencies and the chairs and ranking minority members of the legislative committees with~~
87.19 ~~jurisdiction over child care, and shall post the report to the department's website.~~ (g) Beginning
87.20 July 1, 2020, the commissioner may issue a fix-it ticket to a family child care license holder
87.21 if, upon inspection, the commissioner finds a Level 3 violation as provided in section
87.22 245A.055, subdivision 3.

87.23 Subd. 2. Fix-it ticket laws and rules. (a) For family child care license holders, violations
87.24 of the following laws and rules may qualify only for a fix-it ticket: 9502.0335, subpart 10;
87.25 9502.0375, subpart 2; 9502.0395; 9502.0405, subpart 3; 9502.0405, subpart 4, item A;
87.26 9502.0415, subpart 3; 9502.0425, subpart 2 (outdoor play spaces must be free from litter,
87.27 rubbish, unlocked vehicles, or human or animal waste); 9502.0425, subpart 3 (wading pools
87.28 must be kept clean); 9502.0425, subpart 5; 9502.0425, subpart 7, item F (screens on exterior
87.29 doors and windows when biting insects are prevalent); 9502.0425, subpart 8; 9502.0425,
87.30 subpart 10; 9502.0425, subpart 11 (decks free of splinters); 9502.0425, subpart 13 (toilets
87.31 flush thoroughly); 9502.0425, subpart 16; 9502.0435, subpart 1; 9502.0435, subpart 3;
87.32 9502.0435, subpart 7; 9502.0435, subpart 8, item B; 9502.0435, subpart 8, item E; 9502.0435,
87.33 subpart 12, items A through E; 9502.0435, subpart 13; 9502.0435, subpart 14; 9502.0435,
87.34 subpart 15; 9502.0435, subpart 15, items A and B; 9502.0445, subpart 1, item B; 9502.0445,

88.1 subpart 3, items B through D; 9502.0445, subpart 4, items A through C; 245A.04, subdivision
 88.2 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.146, subdivision
 88.3 3, paragraph (c); 245A.148; 245A.152; 245A.50, subdivision 7; 245A.51, subdivision 3,
 88.4 paragraph (d) (emergency preparedness plan available for review and posted in prominent
 88.5 location).

88.6 (b) For child care center license holders, violations of the following laws and rules may
 88.7 qualify only for a fix-it ticket: 9503.0120, item B; 9503.0120, item E; 9503.0125, item E;
 88.8 9503.0125, item F; 9503.0125, item I; 9503.0125, item M; 9503.0140, subpart 2; 9503.0140,
 88.9 subpart 7, item D; 9503.0140, subpart 9; 9503.0140, subpart 10; 9503.0140, subpart 13;
 88.10 9503.0140, subpart 14; 9503.0140, subpart 15; 9503.0140, subpart 16 (item missing from
 88.11 first-aid kit); 9503.0140, subpart 18; 9503.0140, subpart 19; 9503.0140, subpart 20;
 88.12 9503.0140, subpart 21 (emergency plan not posted in prominent place); 9503.0145, subpart
 88.13 2; 9503.0145, subpart 3; 9503.0145, subpart 4, item D; 9503.0145, subpart 8 (drinking water
 88.14 provided in single service cups or at an accessible drinking fountain); 9503.0155, subpart
 88.15 7, item D; 9503.0155, subpart 13; 9503.0155, subpart 16; 9503.0155, subpart 17; 9503.0155,
 88.16 subpart 18, item D; 9503.0170, subpart 3; 9503.0145, subpart 7, item D; 245A.04, subdivision
 88.17 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.14, subdivision
 88.18 8, paragraph (b) (experienced aide identification posting); 245A.146, subdivision 3, paragraph
 88.19 (c); 245A.152; 245A.41, subdivision 3, paragraph (d); 245A.41, subdivision 3, paragraph
 88.20 (e); 245A.41, subdivision 3, paragraph (f).

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

88.22 Sec. 12. **[245A.066] CHILD CARE TECHNICAL ASSISTANCE.**

88.23 Subdivision 1. **Verbal technical assistance.** The commissioner may provide verbal
 88.24 technical assistance to a family child care license holder if, upon inspection, the commissioner
 88.25 finds a Level 1 violation as provided in section 245A.055, subdivision 3.

88.26 Subd. 2. **Technical assistance notice.** (a) The commissioner may issue a written technical
 88.27 assistance notice to a family child care license holder if, upon inspection, the commissioner
 88.28 finds a Level 2 violation as provided in section 245A.055, subdivision 3.

88.29 (b) The technical assistance notice must state:

88.30 (1) the conditions that constitute a violation of the law or rule;

88.31 (2) the specific law or rule violated; and

88.32 (3) examples of how to correct the violation.

89.1 (c) The commissioner shall not publicly publish a written technical assistance notice on
89.2 the department's website, unless required by federal law.

89.3 **EFFECTIVE DATE.** This section is effective July 1, 2020.

89.4 Sec. 13. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

89.5 Subd. 4. **Special family day care homes.** Nonresidential child care programs serving
89.6 14 or fewer children that are conducted at a location other than the license holder's own
89.7 residence shall be licensed under this section and the rules governing family day care or
89.8 group family day care if:

89.9 (a) The license holder is the primary provider of care and the nonresidential child care
89.10 program is conducted in a dwelling that is located on a residential lot;

89.11 (b) The license holder is an employer who may or may not be the primary provider of
89.12 care, and the purpose for the child care program is to provide child care services to children
89.13 of the license holder's employees;

89.14 (c) The license holder is a church or religious organization;

89.15 (d) The license holder is a community collaborative child care provider. For purposes
89.16 of this subdivision, a community collaborative child care provider is a provider participating
89.17 in a cooperative agreement with a community action agency as defined in section 256E.31;

89.18 (e) The license holder is a not-for-profit agency that provides child care in a dwelling
89.19 located on a residential lot and the license holder maintains two or more contracts with
89.20 community employers or other community organizations to provide child care services.
89.21 The county licensing agency may grant a capacity variance to a license holder licensed
89.22 under this paragraph to exceed the licensed capacity of 14 children by no more than five
89.23 children during transition periods related to the work schedules of parents, if the license
89.24 holder meets the following requirements:

89.25 (1) the program does not exceed a capacity of 14 children more than a cumulative total
89.26 of four hours per day;

89.27 (2) the program meets a one to seven staff-to-child ratio during the variance period;

89.28 (3) all employees receive at least an extra four hours of training per year than required
89.29 in the rules governing family child care each year;

89.30 (4) the facility has square footage required per child under Minnesota Rules, part
89.31 9502.0425;

90.1 (5) the program is in compliance with local zoning regulations;

90.2 (6) the program is in compliance with the applicable fire code as follows:

90.3 (i) if the program serves more than five children older than 2-1/2 years of age, but no
 90.4 more than five children 2-1/2 years of age or less, the applicable fire code is educational
 90.5 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003,
 90.6 Section 202; or

90.7 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
 90.8 fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2003,
 90.9 Section 202; and

90.10 (7) any age and capacity limitations required by the fire code inspection and square
 90.11 footage determinations shall be printed on the license; ~~or~~

90.12 (f) The license holder is the primary provider of care and has located the licensed child
 90.13 care program in a commercial space, if the license holder meets the following requirements:

90.14 (1) the program is in compliance with local zoning regulations;

90.15 (2) the program is in compliance with the applicable fire code as follows:

90.16 (i) if the program serves more than five children older than 2-1/2 years of age, but no
 90.17 more than five children 2-1/2 years of age or less, the applicable fire code is educational
 90.18 occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003,
 90.19 Section 202; or

90.20 (ii) if the program serves more than five children 2-1/2 years of age or less, the applicable
 90.21 fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2003,
 90.22 Section 202;

90.23 (3) any age and capacity limitations required by the fire code inspection and square
 90.24 footage determinations are printed on the license; and

90.25 (4) the license holder prominently displays the license issued by the commissioner which
 90.26 contains the statement "This special family child care provider is not licensed as a child
 90.27 care center-"; or

90.28 (g) The license holder is the primary provider of care and has located the licensed child
 90.29 care program in a portion of a building that is used exclusively for the purpose of providing
 90.30 child care services, if the license holder meets the requirements in paragraph (f), clauses
 90.31 (1) to (4), and if any available shared kitchen, bathroom, or other space that the provider
 90.32 uses is separate from the indoor activity area used by the children.

91.1 Sec. 14. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision
91.2 to read:

91.3 Subd. 16. **Water bottles in child care centers.** Notwithstanding Minnesota Rules, part
91.4 9503.0145, subpart 8, a child care center may provide drinking water for children in
91.5 individual covered water bottles, labeled with the child's name. Water bottles provided by
91.6 the child care center must be washed, rinsed, and sanitized daily after use and stored clean
91.7 and dry in a manner that protects them from contamination.

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

91.9 Sec. 15. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

91.10 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private
91.11 agencies that have been designated or licensed by the commissioner to perform licensing
91.12 functions and activities under section 245A.04 and background studies for family child care
91.13 under chapter 245C; to recommend denial of applicants under section 245A.05; to issue
91.14 correction orders, to issue variances, and recommend a conditional license under section
91.15 245A.06; or to recommend suspending or revoking a license or issuing a fine under section
91.16 245A.07, shall comply with rules and directives of the commissioner governing those
91.17 functions and with this section. The following variances are excluded from the delegation
91.18 of variance authority and may be issued only by the commissioner:

91.19 (1) dual licensure of family child care and child foster care, dual licensure of child and
91.20 adult foster care, and adult foster care and family child care;

91.21 (2) adult foster care maximum capacity;

91.22 (3) adult foster care minimum age requirement;

91.23 (4) child foster care maximum age requirement;

91.24 (5) variances regarding disqualified individuals except that, before the implementation
91.25 of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding
91.26 disqualified individuals when the county is responsible for conducting a consolidated
91.27 reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and
91.28 (b), of a county maltreatment determination and a disqualification based on serious or
91.29 recurring maltreatment;

91.30 (6) the required presence of a caregiver in the adult foster care residence during normal
91.31 sleeping hours; and

92.1 (7) variances to requirements relating to chemical use problems of a license holder or a
92.2 household member of a license holder.

92.3 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must
92.4 not grant a license holder a variance to exceed the maximum allowable family child care
92.5 license capacity of 14 children.

92.6 (b) Before the implementation of NETStudy 2.0, county agencies must report information
92.7 about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision
92.8 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the
92.9 commissioner at least monthly in a format prescribed by the commissioner.

92.10 (c) For family child care programs, the commissioner shall require a county agency to
92.11 conduct one unannounced licensing ~~review~~ inspection at least annually.

92.12 (d) For family adult day services programs, the commissioner may authorize licensing
92.13 reviews every two years after a licensee has had at least one annual review.

92.14 (e) A license issued under this section may be issued for up to two years.

92.15 (f) During implementation of chapter 245D, the commissioner shall consider:

92.16 (1) the role of counties in quality assurance;

92.17 (2) the duties of county licensing staff; and

92.18 (3) the possible use of joint powers agreements, according to section 471.59, with counties
92.19 through which some licensing duties under chapter 245D may be delegated by the
92.20 commissioner to the counties.

92.21 Any consideration related to this paragraph must meet all of the requirements of the corrective
92.22 action plan ordered by the federal Centers for Medicare and Medicaid Services.

92.23 (g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
92.24 successor provisions; and section 245D.061 or successor provisions, for family child foster
92.25 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
92.26 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and
92.27 private agencies.

92.28 (h) A county agency shall report to the commissioner, in a manner prescribed by the
92.29 commissioner, the following information for a licensed family child care program:

92.30 (1) the results of each licensing ~~review~~ inspection completed, including the date of the
92.31 ~~review~~ inspection, and any ~~licensing~~ correction order issued; and

93.1 (2) any death, serious injury, or determination of substantiated maltreatment.

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

93.3 Sec. 16. Minnesota Statutes 2018, section 245A.50, subdivision 1, is amended to read:

93.4 Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must
93.5 comply with the training requirements in this section.

93.6 (b) Helpers who assist with care on a regular basis must complete six hours of training
93.7 within one year after the date of initial employment.

93.8 (c) Training requirements established under this section that must be completed prior
93.9 to initial licensure must be satisfied only by a newly licensed child care provider or by a
93.10 child care provider who has not held an active child care license in Minnesota in the previous
93.11 12 months. A child care provider ~~who relocates within the state or who voluntarily cancels~~
93.12 a license or allows the license to lapse for a period of less than 12 months and who seeks
93.13 reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation
93.14 must satisfy the annual, ongoing training requirements, and is not required to satisfy the
93.15 training requirements that must be completed prior to initial licensure. A child care provider
93.16 who relocates within the state must (1) satisfy the annual, ongoing training requirements
93.17 according to the schedules established in this section and (2) not be required to satisfy the
93.18 training requirements under this section that the child care provider completed prior to initial
93.19 licensure. If a licensed provider moves to a new county, the new county is prohibited from
93.20 requiring the provider to complete any orientation class or training for new providers.

93.21 Sec. 17. Minnesota Statutes 2018, section 245A.50, subdivision 2, is amended to read:

93.22 Subd. 2. **Child development and learning and behavior guidance training.** (a) For
93.23 purposes of family and group family child care, the license holder and each adult caregiver
93.24 who provides care in the licensed setting for more than 30 days in any 12-month period
93.25 shall complete and document at least four hours of child growth and learning and behavior
93.26 guidance training prior to initial licensure, and before caring for children. For purposes of
93.27 this subdivision, "child development and learning training" means training in understanding
93.28 how children develop physically, cognitively, emotionally, and socially and learn as part
93.29 of the children's family, culture, and community. "Behavior guidance training" means
93.30 training in the understanding of the functions of child behavior and strategies for managing
93.31 challenging situations. ~~At least two hours of child development and learning or behavior~~
93.32 ~~guidance training must be repeated annually.~~ The training curriculum shall be developed
93.33 or approved by the commissioner of human services.

- 94.1 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:
- 94.2 (1) have taken a three-credit course on early childhood development within the past five
- 94.3 years;
- 94.4 (2) have received a baccalaureate or master's degree in early childhood education or
- 94.5 school-age child care within the past five years;
- 94.6 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator,
- 94.7 a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special
- 94.8 education teacher, or an elementary teacher with a kindergarten endorsement; or
- 94.9 (4) have received a baccalaureate degree with a Montessori certificate within the past
- 94.10 five years.

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

94.12 Sec. 18. Minnesota Statutes 2018, section 245A.50, subdivision 3, is amended to read:

94.13 Subd. 3. **First aid.** (a) When children are present in a family child care home governed

94.14 by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present

94.15 in the home who has been trained in first aid. The first aid training must have been provided

94.16 by an individual approved to provide first aid instruction. First aid training may be less than

94.17 eight hours and persons qualified to provide first aid training include individuals approved

94.18 as first aid instructors. First aid training must be repeated ~~every two years~~ before the license

94.19 holder's license expires in the second year after the prior first aid training.

94.20 (b) A family child care provider is exempt from the first aid training requirements under

94.21 this subdivision related to any substitute caregiver who provides less than 30 hours of care

94.22 during any 12-month period.

94.23 (c) Video training reviewed and approved by the county licensing agency satisfies the

94.24 training requirement of this subdivision.

94.25 Sec. 19. Minnesota Statutes 2018, section 245A.50, subdivision 4, is amended to read:

94.26 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family

94.27 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one

94.28 caregiver must be present in the home who has been trained in cardiopulmonary resuscitation

94.29 (CPR), including CPR techniques for infants and children, and in the treatment of obstructed

94.30 airways. The CPR training must have been provided by an individual approved to provide

94.31 CPR instruction, must be repeated at least once ~~every two years~~ before the license holder's

95.1 license expires in the second year after the prior CPR training, and must be documented in
95.2 the caregiver's records.

95.3 (b) A family child care provider is exempt from the CPR training requirement in this
95.4 subdivision related to any substitute caregiver who provides less than 30 hours of care during
95.5 any 12-month period.

95.6 (c) Persons providing CPR training must use CPR training that has been developed:

95.7 (1) by the American Heart Association or the American Red Cross and incorporates
95.8 psychomotor skills to support the instruction; or

95.9 (2) using nationally recognized, evidence-based guidelines for CPR training and
95.10 incorporates psychomotor skills to support the instruction.

95.11 Sec. 20. Minnesota Statutes 2018, section 245A.50, subdivision 5, is amended to read:

95.12 Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a)

95.13 License holders must document that before staff persons, caregivers, and helpers assist in
95.14 the care of infants, they are instructed on the standards in section 245A.1435 and receive
95.15 training on reducing the risk of sudden unexpected infant death. In addition, license holders
95.16 must document that before staff persons, caregivers, and helpers assist in the care of infants
95.17 and children under school age, they receive training on reducing the risk of abusive head
95.18 trauma from shaking infants and young children. The training in this subdivision may be
95.19 provided as initial training under subdivision 1 or ongoing annual training under subdivision
95.20 7.

95.21 (b) Sudden unexpected infant death reduction training required under this subdivision
95.22 must, at a minimum, address the risk factors related to sudden unexpected infant death,
95.23 means of reducing the risk of sudden unexpected infant death in child care, and license
95.24 holder communication with parents regarding reducing the risk of sudden unexpected infant
95.25 death.

95.26 (c) Abusive head trauma training required under this subdivision must, at a minimum,
95.27 address the risk factors related to shaking infants and young children, means of reducing
95.28 the risk of abusive head trauma in child care, and license holder communication with parents
95.29 regarding reducing the risk of abusive head trauma.

95.30 (d) Training for family and group family child care providers must be developed by the
95.31 commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved
95.32 by the Minnesota Center for Professional Development. Sudden unexpected infant death

96.1 reduction training and abusive head trauma training may be provided in a single course of
96.2 no more than two hours in length.

96.3 (e) Sudden unexpected infant death reduction training and abusive head trauma training
96.4 required under this subdivision must be completed in person or as allowed under subdivision
96.5 10, clause (1) or (2), at least once ~~every two years~~ before the license holder's license expires
96.6 in the second year after the prior sudden unexpected infant death reduction training and
96.7 abusive head trauma training. On the years when the license holder is not receiving training
96.8 in person or as allowed under subdivision 10, clause (1) or (2), the license holder must
96.9 receive sudden unexpected infant death reduction training and abusive head trauma training
96.10 through a video of no more than one hour in length. The video must be developed or approved
96.11 by the commissioner.

96.12 (f) An individual who is related to the license holder as defined in section 245A.02,
96.13 subdivision 13, and who is involved only in the care of the license holder's own infant or
96.14 child under school age and who is not designated to be a caregiver, helper, or substitute, as
96.15 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
96.16 sudden unexpected infant death and abusive head trauma training.

96.17 Sec. 21. Minnesota Statutes 2018, section 245A.50, subdivision 6, is amended to read:

96.18 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
96.19 holder must comply with all seat belt and child passenger restraint system requirements
96.20 under section 169.685.

96.21 (b) Family and group family child care programs licensed by the Department of Human
96.22 Services that serve a child or children under ~~nine~~ eight years of age must document training
96.23 that fulfills the requirements in this subdivision.

96.24 (1) Before a license holder, staff person, caregiver, or helper transports a child or children
96.25 under age ~~nine~~ eight in a motor vehicle, the person placing the child or children in a passenger
96.26 restraint must satisfactorily complete training on the proper use and installation of child
96.27 restraint systems in motor vehicles. Training completed under this subdivision may be used
96.28 to meet initial training under subdivision 1 or ongoing training under subdivision 7.

96.29 (2) Training required under this subdivision must be at least one hour in length, completed
96.30 at initial training, and repeated at least once ~~every five years~~ before the license holder's
96.31 license expires in the fifth year after the prior child passenger restraint system training. At
96.32 a minimum, the training must address the proper use of child restraint systems based on the

97.1 child's size, weight, and age, and the proper installation of a car seat or booster seat in the
 97.2 motor vehicle used by the license holder to transport the child or children.

97.3 (3) Training under this subdivision must be provided by individuals who are certified
 97.4 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
 97.5 may obtain a list of certified and approved trainers through the Department of Public Safety
 97.6 website or by contacting the agency.

97.7 (c) Child care providers that only transport school-age children as defined in section
 97.8 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
 97.9 subdivision 1, paragraph (e), are exempt from this subdivision.

97.10 Sec. 22. Minnesota Statutes 2018, section 245A.50, subdivision 7, is amended to read:

97.11 Subd. 7. **Training requirements for family and group family child care.** For purposes
 97.12 of family and group family child care, the license holder and each primary caregiver must
 97.13 complete ~~16~~ ten hours of ongoing training each year. For purposes of this subdivision, a
 97.14 primary caregiver is an adult caregiver who provides services in the licensed setting for
 97.15 more than 30 days in any 12-month period. Repeat of topical training requirements in
 97.16 subdivisions 2 to 8, and the annual refresher training course in subdivision 12, shall count
 97.17 toward the annual ~~16-hour~~ ten-hour training requirement. Additional ongoing training
 97.18 subjects to meet the annual ~~16-hour~~ ten-hour training requirement must be selected from
 97.19 the following areas:

97.20 (1) child development and learning training under subdivision 2, paragraph (a);

97.21 (2) developmentally appropriate learning experiences, including training in creating
 97.22 positive learning experiences, promoting cognitive development, promoting social and
 97.23 emotional development, promoting physical development, promoting creative development;
 97.24 and behavior guidance;

97.25 (3) relationships with families, including training in building a positive, respectful
 97.26 relationship with the child's family;

97.27 (4) assessment, evaluation, and individualization, including training in observing,
 97.28 recording, and assessing development; assessing and using information to plan; and assessing
 97.29 and using information to enhance and maintain program quality;

97.30 (5) historical and contemporary development of early childhood education, including
 97.31 training in past and current practices in early childhood education and how current events
 97.32 and issues affect children, families, and programs;

98.1 (6) professionalism, including training in knowledge, skills, and abilities that promote
 98.2 ongoing professional development; and

98.3 (7) health, safety, and nutrition, including training in establishing healthy practices;
 98.4 ensuring safety; and providing healthy nutrition.

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

98.6 Sec. 23. Minnesota Statutes 2018, section 245A.50, subdivision 9, is amended to read:

98.7 Subd. 9. **Supervising for safety; training requirement.** (a) Before initial licensure and
 98.8 before caring for a child, all family child care license holders and each adult caregiver who
 98.9 provides care in the licensed family child care home for more than 30 days in any 12-month
 98.10 period shall complete and document the completion of the six-hour Supervising for Safety
 98.11 for Family Child Care course developed by the commissioner.

98.12 (b) The family child care license holder and each adult caregiver who provides care in
 98.13 the licensed family child care home for more than 30 days in any 12-month period shall
 98.14 complete and document: the completion of the two-hour courses Health and Safety I and
 98.15 Health and Safety II at least once before the license holder's license expires in the fifth year
 98.16 after the prior supervising for safety training.

98.17 ~~(1) the annual completion of a two-hour active supervision course developed by the~~
 98.18 ~~commissioner; and~~

98.19 ~~(2) the completion at least once every five years of the two-hour courses Health and~~
 98.20 ~~Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either~~
 98.21 ~~training in a given year meets the annual active supervision training requirement in clause~~
 98.22 ~~(1).~~

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

98.24 Sec. 24. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision
 98.25 to read:

98.26 Subd. 12. **Annual refresher training course.** Beginning January 1, 2020, license holders,
 98.27 staff persons, caregivers, substitutes, and helpers must complete an annual refresher training
 98.28 course, as developed by the commissioner of human services. The annual refresher training
 98.29 course must incorporate training on: (1) active supervision; (2) child development and
 98.30 learning, and behavior guidance; and (3) any training required by the child care development
 98.31 block grant. The annual refresher training course shall not exceed two hours. Providers may

99.1 complete the annual refresher training course online through self-study. Providers must
 99.2 document completion of the annual refresher training course.

99.3 Sec. 25. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision
 99.4 to read:

99.5 Subd. 13. **Related individual training exemption.** An individual who is related to a
 99.6 child in a child care program may care for or have contact with that child at the child care
 99.7 site without completing the training requirements under this chapter, unless the individual
 99.8 is designated to be a caregiver, helper, or substitute in the child care program.

99.9 Sec. 26. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision
 99.10 to read:

99.11 Subd. 14. **Emergency substitute caregiver training exemption.** During an emergency,
 99.12 substitute caregivers are exempt from training requirements under this section.

99.13 Sec. 27. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

99.14 Subd. 3. **Emergency preparedness plan.** (a) No later than September 30, 2017, a
 99.15 licensed family child care provider must have a written emergency preparedness plan for
 99.16 emergencies that require evacuation, sheltering, or other protection of children, such as fire,
 99.17 natural disaster, intruder, or other threatening situation that may pose a health or safety
 99.18 hazard to children. The plan must be written on a form developed by the commissioner and
 99.19 updated at least annually. The plan must include:

99.20 (1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

99.21 (2) a designated relocation site and evacuation route;

99.22 (3) procedures for notifying a child's parent or legal guardian of the evacuation,
 99.23 shelter-in-place, or lockdown, including procedures for reunification with families;

99.24 (4) accommodations for a child with a disability or a chronic medical condition;

99.25 (5) procedures for storing a child's medically necessary medicine that facilitate easy
 99.26 removal during an evacuation or relocation;

99.27 (6) procedures for continuing operations in the period during and after a crisis; and

99.28 (7) procedures for communicating with local emergency management officials, law
 99.29 enforcement officials, or other appropriate state or local authorities.

100.1 (b) The license holder must train caregivers before the caregiver provides care and at
 100.2 least annually on the emergency preparedness plan and document completion of this training.

100.3 (c) The license holder must conduct drills according to the requirements in Minnesota
 100.4 Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

100.5 (d) The license holder must have the emergency preparedness plan available for review
 100.6 and posted in a prominent location. ~~The license holder must provide a physical or electronic~~
 100.7 ~~copy of the plan to the child's parent or legal guardian upon enrollment.~~

100.8 Sec. 28. **[245A.60] OMBUDSPERSON FOR CHILD CARE PROVIDERS.**

100.9 Subdivision 1. **Appointment.** The governor shall appoint an ombudsperson in the
 100.10 classified service to assist child care providers, including family child care providers and
 100.11 legal nonlicensed child care providers, with licensing, compliance, and other issues facing
 100.12 child care providers. The ombudsperson must be selected without regard to the person's
 100.13 political affiliation. The ombudsperson shall serve a term of two years and may be removed
 100.14 prior to the end of the term for just cause.

100.15 Subd. 2. **Duties.** (a) The ombudsperson's duties shall include:

100.16 (1) addressing all areas of concern to child care providers related to the provision of
 100.17 child care services, including licensing, correction orders, penalty assessments, complaint
 100.18 investigations, and other interactions with agency staff;

100.19 (2) assisting providers with interactions with county licensors and with appealing
 100.20 correction orders;

100.21 (3) providing recommendations for child care improvement or child care provider
 100.22 education;

100.23 (4) operating a telephone line to answer questions and provide guidance to child care
 100.24 providers; and

100.25 (5) assisting child care license applicants.

100.26 (b) The ombudsperson must report annually by December 31 to the commissioner and
 100.27 the chairs and ranking minority members of the legislative committees with jurisdiction
 100.28 over child care on the services provided by the ombudsperson to child care providers,
 100.29 including the number, types, and locations of child care providers served, and the activities
 100.30 of the ombudsperson to carry out the duties under this section. The commissioner shall
 100.31 determine the form of the report and may specify additional reporting requirements.

101.1 Subd. 3. **Staff.** The ombudsperson may appoint and compensate out of available funds
101.2 a deputy, confidential secretary, and other employees in the unclassified service as authorized
101.3 by law. The ombudsperson and the full-time staff are members of the Minnesota State
101.4 Retirement Association. The ombudsperson may delegate to members of the staff any
101.5 authority or duties of the office except the duty to formally make recommendations to a
101.6 child care provider or reports to the commissioner or the legislature.

101.7 Subd. 4. **Access to records.** (a) The ombudsperson or designee, excluding volunteers,
101.8 has access to data of a state agency necessary for the discharge of the ombudsperson's duties,
101.9 including records classified as confidential data on individuals or private data on individuals
101.10 under chapter 13 or any other law. The ombudsperson's data request must relate to a specific
101.11 case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the
101.12 ombudsperson or designee shall first obtain the individual's consent. If the individual cannot
101.13 consent and has no legal guardian, then access to the data is authorized by this section.

101.14 (b) On a quarterly basis, each state agency responsible for licensing, regulating, and
101.15 enforcing state and federal laws and regulations concerning child care providers must provide
101.16 the ombudsperson copies of all correction orders, penalty assessments, and complaint
101.17 investigation reports for all child care providers.

101.18 Subd. 5. **Independence of action.** In carrying out the duties under this section, the
101.19 ombudsperson shall operate independently of the department and may provide testimony
101.20 or make periodic reports to the legislature to address areas of concern and advocate for child
101.21 care providers.

101.22 Subd. 6. **Civil actions.** The ombudsperson or designee is not civilly liable for any action
101.23 taken under this section if the action was taken in good faith, was within the scope of the
101.24 ombudsperson's authority, and did not constitute willful or reckless misconduct.

101.25 Subd. 7. **Qualifications.** The ombudsperson must be a person who has at least five years
101.26 of experience providing child care. The ombudsperson must be experienced in dealing with
101.27 governmental entities, interpretation of laws and regulations, investigations, record keeping,
101.28 report writing, public speaking, and management. A person is not eligible to serve as the
101.29 ombudsperson while holding public office and must not have been previously employed
101.30 by the Department of Human Services or as a county licenser.

101.31 Subd. 8. **Office support.** The commissioner shall provide the ombudsperson with the
101.32 necessary office space, supplies, equipment, and clerical support to effectively perform the
101.33 duties under this section.

102.1 Subd. 9. **Posting.** (a) The commissioner shall post on the department's website the address
 102.2 and telephone number for the office of the ombudsperson. The commissioner shall provide
 102.3 all child care providers with the address and telephone number of the office. Counties must
 102.4 provide child care providers with the name, address, and telephone number of the office.

102.5 (b) The ombudsperson must approve all posting and notice required by the department
 102.6 and counties under this subdivision.

102.7 Sec. 29. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

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

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

102.22 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
 102.23 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
 102.24 contribution shall be determined using a sliding fee scale established by the commissioner
 102.25 of human services which begins at 1.94 percent of adjusted gross income at 275 percent of
 102.26 federal poverty guidelines and increases to 5.29 percent of adjusted gross income for those
 102.27 with adjusted gross income up to 545 percent of federal poverty guidelines;

102.28 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
 102.29 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
 102.30 5.29 percent of adjusted gross income;

102.31 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
 102.32 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution
 102.33 shall be determined using a sliding fee scale established by the commissioner of human

103.1 services which begins at 5.29 percent of adjusted gross income at 675 percent of federal
103.2 poverty guidelines and increases to 7.05 percent of adjusted gross income for those with
103.3 adjusted gross income up to 975 percent of federal poverty guidelines; and

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

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

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

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

103.21 (e) The contribution shall be explained in writing to the parents at the time eligibility
103.22 for services is being determined. The contribution shall be made on a monthly basis effective
103.23 with the first month in which the child receives services. Annually upon redetermination
103.24 or at termination of eligibility, if the contribution exceeded the cost of services provided,
103.25 the local agency or the state shall reimburse that excess amount to the parents, either by
103.26 direct reimbursement if the parent is no longer required to pay a contribution, or by a
103.27 reduction in or waiver of parental fees until the excess amount is exhausted. All
103.28 reimbursements must include a notice that the amount reimbursed may be taxable income
103.29 if the parent paid for the parent's fees through an employer's health care flexible spending
103.30 account under the Internal Revenue Code, section 125, and that the parent is responsible
103.31 for paying the taxes owed on the amount reimbursed.

103.32 (f) The monthly contribution amount must be reviewed at least every 12 months; when
103.33 there is a change in household size; and when there is a loss of or gain in income from one
103.34 month to another in excess of ten percent. The local agency shall mail a written notice 30

104.1 days in advance of the effective date of a change in the contribution amount. A decrease in
104.2 the contribution amount is effective in the month that the parent verifies a reduction in
104.3 income or change in household size.

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

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

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

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

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

104.25 (2) the insurer denied insurance;

104.26 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
104.27 complaint or appeal, in writing, to the commissioner of health or the commissioner of
104.28 commerce, or litigated the complaint or appeal; and

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

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

104.31 A parent who has requested a reduction in the contribution amount under this paragraph
104.32 shall submit proof in the form and manner prescribed by the commissioner or county agency,
104.33 including, but not limited to, the insurer's denial of insurance, the written letter or complaint

105.1 of the parents, court documents, and the written response of the insurer approving insurance.
105.2 The determinations of the commissioner or county agency under this paragraph are not rules
105.3 subject to chapter 14.

105.4 Sec. 30. [256.4751] PARENT-TO-PARENT PEER SUPPORT GRANTS.

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

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

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

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

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

105.16 (3) facilitates ongoing peer support for parents and guardians from trained volunteer
105.17 support parents;

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

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

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

105.22 (e) Grant recipients must report to the commissioner of human services annually by
105.23 January 15 on the services and programs funded by the appropriation. The report must
105.24 include measurable outcomes from the previous year, including the number of families
105.25 served and the number of volunteer support parents trained.

105.26 Sec. 31. Minnesota Statutes 2018, section 256B.14, subdivision 2, is amended to read:

105.27 Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to
105.28 determine the ability of responsible relatives to contribute partial or complete payment or
105.29 repayment of medical assistance furnished to recipients for whom they are responsible. All
105.30 medical assistance exclusions shall be allowed, and a resource limit of \$10,000 for
105.31 nonexcluded resources shall be implemented. Above these limits, a contribution of one-third

106.1 of the excess resources shall be required. These rules shall not require payment or repayment
 106.2 when payment would cause undue hardship to the responsible relative or that relative's
 106.3 immediate family. These rules shall ~~be consistent with the requirements of section 252.27~~
 106.4 ~~for~~ not apply to parents of children whose eligibility for medical assistance was determined
 106.5 without deeming of the parents' resources and income under the TEFRA option or for the
 106.6 purposes of accessing home and community-based waiver services. The county agency
 106.7 shall give the responsible relative notice of the amount of the payment or repayment. If the
 106.8 state agency or county agency finds that notice of the payment obligation was given to the
 106.9 responsible relative, but that the relative failed or refused to pay, a cause of action exists
 106.10 against the responsible relative for that portion of medical assistance granted after notice
 106.11 was given to the responsible relative, which the relative was determined to be able to pay.

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

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

106.20 Sec. 32. Minnesota Statutes 2018, section 256M.41, subdivision 3, is amended to read:

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

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

106.26 ~~(1) 80 percent of the allocation as determined in subdivision 1 must be paid to counties~~
 106.27 ~~on or before July 10 of each year;~~

106.28 ~~(2) ten percent of the allocation shall be withheld until the commissioner determines if~~
 106.29 ~~the county has met the performance outcome threshold of 90 percent based on face-to-face~~
 106.30 ~~contact with alleged child victims. In order to receive the performance allocation, the county~~
 106.31 ~~child protection workers must have a timely face-to-face contact with at least 90 percent of~~
 106.32 ~~all alleged child victims of screened-in maltreatment reports. The standard requires that~~
 106.33 ~~each initial face-to-face contact occur consistent with timelines defined in section 626.556,~~

107.1 ~~subdivision 10, paragraph (i). The commissioner shall make threshold determinations in~~
107.2 ~~January of each year and payments to counties meeting the performance outcome threshold~~
107.3 ~~shall occur in February of each year. Any withheld funds from this appropriation for counties~~
107.4 ~~that do not meet this requirement shall be reallocated by the commissioner to those counties~~
107.5 ~~meeting the requirement; and~~

107.6 ~~(3) ten percent of the allocation shall be withheld until the commissioner determines~~
107.7 ~~that the county has met the performance outcome threshold of 90 percent based on~~
107.8 ~~face-to-face visits by the case manager. In order to receive the performance allocation, the~~
107.9 ~~total number of visits made by caseworkers on a monthly basis to children in foster care~~
107.10 ~~and children receiving child protection services while residing in their home must be at least~~
107.11 ~~90 percent of the total number of such visits that would occur if every child were visited~~
107.12 ~~once per month. The commissioner shall make such determinations in January of each year~~
107.13 ~~and payments to counties meeting the performance outcome threshold shall occur in February~~
107.14 ~~of each year. Any withheld funds from this appropriation for counties that do not meet this~~
107.15 ~~requirement shall be reallocated by the commissioner to those counties meeting the~~
107.16 ~~requirement. For 2015, the commissioner shall only apply the standard for monthly foster~~
107.17 ~~care visits.~~

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

107.25 Sec. 33. Minnesota Statutes 2018, section 256M.41, is amended by adding a subdivision
107.26 to read:

107.27 Subd. 4. County performance on child protection measures. The commissioner shall
107.28 set child protection measures and standards. The commissioner shall require an
107.29 underperforming county to demonstrate that the county designated sufficient funds and
107.30 implemented a reasonable strategy to improve child protection performance, including the
107.31 provision of a performance improvement plan and additional remedies identified by the
107.32 commissioner. The commissioner may redirect up to 20 percent of a county's funds under
107.33 this section toward the performance improvement plan. Sanctions under section 256M.20,
107.34 subdivision 3, related to noncompliance with federal performance standards also apply.

108.1 Sec. 34. **[260C.216] FOSTER CARE RECRUITMENT GRANT PROGRAM.**

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

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

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

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

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

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

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

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

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

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

108.29 **Subd. 4. Reporting** The commissioner shall report on the use of foster care recruitment
108.30 grants to the chairs and ranking minority members of the legislative committees with
108.31 jurisdiction over human services by December 31, 2020. The report shall include the name
108.32 and location of grant recipients, the amount of each grant, the services provided, and the

109.1 effects on the foster care system. The commissioner shall determine the form required for
 109.2 the report and may specify additional reporting requirements.

109.3 Subd. 5. **Funding.** The commissioner of human services may use available parent support
 109.4 outreach program funds for foster care recruitment grants under Minnesota Statutes, section
 109.5 260C.216.

109.6 **Sec. 35. [260C.218] PARENT SUPPORT FOR BETTER OUTCOMES GRANTS.**

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

109.12 **Sec. 36. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:**

109.13 **Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed****
 109.14 **on a less than full-time basis.** A parent is not considered voluntarily unemployed,
 109.15 underemployed, or employed on a less than full-time basis upon a showing by the parent
 109.16 that:

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

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

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

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

109.26 **Sec. 37. Minnesota Statutes 2018, section 518A.51, is amended to read:**

109.27 **518A.51 FEES FOR IV-D SERVICES.**

109.28 (a) When a recipient of IV-D services is no longer receiving assistance under the state's
 109.29 title IV-A, IV-E foster care, or medical assistance programs, the public authority responsible
 109.30 for child support enforcement must notify the recipient, within five working days of the
 109.31 notification of ineligibility, that IV-D services will be continued unless the public authority

110.1 is notified to the contrary by the recipient. The notice must include the implications of
110.2 continuing to receive IV-D services, including the available services and fees, cost recovery
110.3 fees, and distribution policies relating to fees.

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

110.10 (c) When the public authority provides full IV-D services to an obligee who has applied
110.11 for those services, upon written notice to the obligee, the public authority must charge a
110.12 cost recovery fee of two percent of the amount collected. This fee must be deducted from
110.13 the amount of the child support and maintenance collected and not assigned under section
110.14 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

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

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

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

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

110.31 (f) Federal collections fees collected under paragraph (b) and cost recovery fees collected
110.32 under paragraphs (c) and (d) retained by the commissioner of human services shall be
110.33 considered child support program income according to Code of Federal Regulations, title
110.34 45, section 304.50, and shall be deposited in the special revenue fund account established

111.1 under paragraph (h). The commissioner of human services must elect to recover costs based
111.2 on either actual or standardized costs.

111.3 (g) The limitations of this section on the assessment of fees shall not apply to the extent
111.4 inconsistent with the requirements of federal law for receiving funds for the programs under
111.5 title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections
111.6 601 to 613 and United States Code, title 42, sections 651 to 662.

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

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

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

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

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

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

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

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

111.27 Sec. 38. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA**
111.28 **OPTION IMPROVEMENT MEASURES.**

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

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

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

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

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

112.23 **Sec. 39. MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT**
 112.24 **PROJECT.**

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

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

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

113.1 (2) identification of data sharing requirements between the counties and the commissioner
113.2 to administer the pilot project and evaluate the outcome measures under subdivision 4,
113.3 including the technology systems that will be developed to administer the pilot project and
113.4 a description of the elements of the technology systems that will ensure the privacy of the
113.5 data of the participants and provide financial oversight and accountability for expended
113.6 funds;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

115.8 Sec. 40. **DIRECTION TO COMMISSIONER; CHILD CARE ASSISTANCE**
115.9 **PROGRAM REDESIGN.**

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

115.16 (1) eliminates fraud;

115.17 (2) eliminates program inefficiencies;

115.18 (3) eliminates barriers to families entering the program;

115.19 (4) improves accessibility to child care for families in greater Minnesota and in the
115.20 metropolitan area;

115.21 (5) improves the quality of available child care;

115.22 (6) eliminates assistance rate disparities between greater Minnesota and the metropolitan
115.23 area;

115.24 (7) ensures future access to assistance and child care for families in greater Minnesota
115.25 and in the metropolitan area;

115.26 (8) develops additional options for providers to complete required training including
115.27 through online or remote access;

115.28 (9) improves ease of provider access to required training and quality improvement
115.29 resources;

115.30 (10) reforms the Parent Aware program, including by removing barriers to participation
115.31 for family child care providers, by implementing a method for evaluating the quality and

116.1 effectiveness of four-star rated programs, and by incorporating licensing violations, sanctions,
116.2 or maltreatment determinations into the star-rating program standards;

116.3 (11) proposes legislation that codifies Parent Aware program standards;

116.4 (12) implements a licensing and inspection structure based on differential monitoring;

116.5 (13) amends licensing requirements that have led to closure of child care programs,
116.6 especially family child care programs;

116.7 (14) recommends business development and technical assistance resources to promote
116.8 provider recruitment and retention;

116.9 (15) allows for family child care licensing alternatives, including permitting multiple
116.10 family child care providers to operate in a commercial or other building other than the
116.11 providers' residences; and

116.12 (16) improves family child care licensing efficiencies, including by adding a variance
116.13 structure and updating child ratios.

116.14 (b) The commissioner shall seek all necessary federal waivers to implement the proposed
116.15 redesign described in paragraph (a), including to authorize use of existing federal funding.

116.16 Sec. 41. **DIRECTION TO COMMISSIONER; ABBREVIATED INSPECTION**
116.17 **MODEL.**

116.18 (a) By January 1, 2020, the commissioner of human services shall, following consultation
116.19 with family child care license holders, parents, and county agencies, develop the key
116.20 indicators for use in the abbreviated inspection process under Minnesota Statutes, section
116.21 245A.055, subdivision 2, paragraph (c), and report the results to the chairs and ranking
116.22 minority members of the legislative committees with jurisdiction over child care. In
116.23 developing the key indicators that predict full compliance with the statutes and rules
116.24 governing licensed child care providers, the commissioner shall utilize an empirically based
116.25 statistical methodology similar to the licensing key indicator systems as developed by the
116.26 National Association for Regulatory Administration and the Research Institute for Key
116.27 Indicators.

116.28 (b) By July 1, 2020, the commissioner of human services shall develop, distribute, and
116.29 provide training to implement abbreviated inspections as described in Minnesota Statutes,
116.30 section 245A.055, subdivision 2, paragraph (c).

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

117.1 Sec. 42. **DIRECTION TO COMMISSIONER; CHILD CARE TRAINING**
117.2 **REQUIREMENTS.**

117.3 (a) The commissioner of human services shall develop an annual refresher course as
117.4 described in Minnesota Statutes, section 245A.50, subdivision 12, for child care providers
117.5 who previously completed the training requirements under Minnesota Statutes, chapter
117.6 245A.

117.7 (b) The commissioner must propose any necessary legislative changes to develop and
117.8 implement the annual refresher training course in paragraph (a) and to eliminate duplicative
117.9 training requirements for the 2020 legislative session.

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

117.11 Sec. 43. **DIRECTION TO COMMISSIONER; CORRECTION ORDER**
117.12 **ENFORCEMENT REVIEW.**

117.13 By January 1, 2020, the commissioner of human services shall develop and implement
117.14 a process to review licensing inspection results provided under Minnesota Statutes, section
117.15 245A.16, subdivision 1, paragraph (h), clause (1), by county to identify trends in correction
117.16 order enforcement. The commissioner shall develop guidance and training as needed to
117.17 address any imbalance or inaccuracy in correction order enforcement. The commissioner
117.18 shall include the results in the annual report on child care under Minnesota Statutes, section
117.19 245A.153, provided that the results are limited to summary data as defined in Minnesota
117.20 Statutes, section 13.02, subdivision 19.

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

117.22 Sec. 44. **DIRECTION TO COMMISSIONER; SUBSTITUTE CAREGIVER**
117.23 **PERMISSION.**

117.24 (a) The commissioner of human services shall amend Minnesota Rules, part 9502.0365,
117.25 subpart 5, to permit licensed providers to use substitute caregivers for a cumulative total of
117.26 720 hours in any 12-month period.

117.27 (b) The commissioner of human services may use the good cause exemption under
117.28 Minnesota Statutes, section 14.388, subdivision 1, clause (3), to adopt rules under this
117.29 section, and Minnesota Statutes, section 14.386, does not apply except as provided under
117.30 Minnesota Statutes, section 14.388.

118.1 Sec. 45. **FAMILY CHILD CARE TASK FORCE.**

118.2 Subdivision 1. **Membership.** (a) The Family Child Care Task Force shall consist of 14
118.3 members, appointed as follows:

118.4 (1) two members representing family child care providers from greater Minnesota,
118.5 including one appointed by the speaker of the house of representatives and one appointed
118.6 by the senate majority leader;

118.7 (2) two members representing family care providers from the metropolitan area as defined
118.8 in Minnesota Statutes, section 473.121, subdivision 2, including one appointed by the speaker
118.9 of the house of representatives and one appointed by the senate majority leader;

118.10 (3) two members appointed by the Minnesota Association of Child Care Professionals;

118.11 (4) two members appointed by the Minnesota Child Care Provider Information Network;

118.12 (5) two members representing Department of Human Services-recognized family child
118.13 care associations from greater Minnesota, including one appointed by the senate majority
118.14 leader and one appointed by the senate minority leader;

118.15 (6) two members appointed by the Association of Minnesota Child Care Licensors,
118.16 including one from greater Minnesota and one from the metropolitan area, as defined in
118.17 Minnesota Statutes, section 473.121, subdivision 2;

118.18 (7) one member appointed by the Greater Minnesota Partnership; and

118.19 (8) one member appointed by the Minnesota Chamber of Commerce.

118.20 (b) Appointments to the task force must be made by June 15, 2019.

118.21 Subd. 2. **Compensation.** Public members of the task force may be compensated as
118.22 provided by Minnesota Statutes, section 15.059, subdivision 3.

118.23 Subd. 3. **Duties.** The task force must:

118.24 (1) identify difficulties that providers face regarding licensing and inspection, including
118.25 licensing requirements that have led to the closure of family child care programs; propose
118.26 regulatory reforms to improve licensing efficiency, including a variance structure and
118.27 updated child ratios; and recommend business development and technical assistance resources
118.28 to promote provider recruitment and retention;

118.29 (2) identify alternative family child care business models, including permitting multiple
118.30 family child care providers to operate in a building other than the providers' residences; and

119.1 (3) review Parent Aware program participation and identify obstacles and suggested
119.2 improvements.

119.3 Subd. 4. **Officers; meetings.** (a) The task force must elect a chair and vice-chair from
119.4 among its members and may elect other officers as necessary.

119.5 (b) The task force must meet at least three times. The commissioner of human services
119.6 must convene the first meeting by August 1, 2019, at which the task force must at least
119.7 make introductions, identify concerns of the members and issues related to the duties under
119.8 subdivision 4, and assign tasks for each member to complete before the second meeting.

119.9 The chair must convene the second meeting by November 1, 2019, at which the task force
119.10 must at least review members' work on the tasks from the first meeting and develop a plan
119.11 for members to create proposals relating to the duties of the task force under subdivision 4.
119.12 The chair must convene the third meeting by February 1, 2020, at which the task force must
119.13 at least discuss which of the members' proposals to include in its final report.

119.14 (c) In accordance with paragraph (b), the agenda for each meeting must be determined
119.15 by the chair and vice-chair.

119.16 (d) Meetings of the task force are subject to the Minnesota Open Meeting Law under
119.17 Minnesota Statutes, chapter 13D.

119.18 Subd. 5. **Administrative support.** The division of child care licensing in the Department
119.19 of Human Services must provide administrative support and meeting space to support the
119.20 task force as needed.

119.21 Subd. 6. **Report required.** By March 1, 2020, the task force must submit a written report
119.22 to the chairs and ranking minority members of the committees in the house of representatives
119.23 and the senate with jurisdiction over child care. The report must include:

119.24 (1) a description of the difficulties that providers face regarding licensing and inspection,
119.25 and recommendations for addressing those difficulties;

119.26 (2) a description of alternative family child care business models, and recommendations
119.27 for facilitating the delivery of child care through those alternative models;

119.28 (3) a description of obstacles to participation in the Parent Aware program and
119.29 recommendations for increasing participation; and

119.30 (4) any draft legislation necessary to implement the recommendations.

119.31 Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision
119.32 6 or March 1, 2020, whichever is later.

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

120.2 Sec. 46. **INSTRUCTION TO COMMISSIONER; REVIEW OF CHILD CARE**
120.3 **LICENSING AND BACKGROUND STUDY PROVISIONS.**

120.4 The commissioner of human services shall review existing statutes and rules relating to
120.5 child care licensing and background study requirements and propose legislation for the 2020
120.6 legislative session that eliminates unnecessary and duplicative record keeping or
120.7 documentation requirements for child care providers. The commissioner shall also establish
120.8 a process for child care providers to electronically submit requested information to the
120.9 commissioner.

120.10 Sec. 47. **REVISOR INSTRUCTION.**

120.11 The revisor of statutes, in consultation with the Department of Human Services, House
120.12 Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the
120.13 terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program"
120.14 or "SNAP" in Minnesota Statutes when appropriate. The revisor may make technical and
120.15 other necessary changes to sentence structure to preserve the meaning of the text.

120.16 Sec. 48. **REVISOR INSTRUCTION.**

120.17 The revisor of statutes shall remove the terms "child care assistance program," "basic
120.18 sliding fee child care," and "MFIP child care," or similar terms wherever the terms appear
120.19 in Minnesota Statutes. The revisor shall also make technical and other necessary changes
120.20 to sentence structure to preserve the meaning of the text.

120.21 **EFFECTIVE DATE.** This section is effective July 1, 2020.

120.22 Sec. 49. **REVISOR INSTRUCTION; MINNESOTA RULES, CHAPTER 9502.**

120.23 The revisor of statutes, in consultation with the House Research Department, Office of
120.24 Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services shall
120.25 prepare legislation for the 2020 legislative session to repeal and enact as statutes Minnesota
120.26 Rules, chapter 9502, and recodify Minnesota Statutes sections governing licensing of child
120.27 care facilities. The revisor of statutes shall provide a courtesy copy of the proposed legislation
120.28 to the chief authors in the house of representatives and senate of this act.

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

121.1 **Sec. 50. REVISOR INSTRUCTION; MINNESOTA RULES, CHAPTER 9503.**

121.2 The revisor of statutes, in consultation with the House Research Department, Office of
 121.3 Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services shall
 121.4 prepare legislation for the 2020 legislative session to repeal and enact as statutes Minnesota
 121.5 Rules, chapter 9503, and recodify Minnesota Statutes sections governing licensing of child
 121.6 care facilities. The revisor of statutes shall provide a courtesy copy of the proposed legislation
 121.7 to the chief authors in the house of representatives and senate of this act.

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

121.9 **Sec. 51. REVISOR INSTRUCTION; RECODIFY MINNESOTA STATUTES,**
 121.10 **CHAPTER 245A; RECODIFY MINNESOTA RULES, CHAPTER 9502.**

121.11 The revisor of statutes, in consultation with the House Research Department, Office of
 121.12 Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
 121.13 prepare legislation for the 2020 legislative session to: (1) recodify Minnesota Statutes,
 121.14 chapter 245A; and (2) repeal and enact as statutes the rules governing day care facility
 121.15 licensing in Minnesota Rules, chapter 9502.

121.16 **Sec. 52. REPEALER.**

121.17 (a) Minnesota Statutes 2018, sections 119B.011, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10,
 121.18 10a, 11, 12, 13, 13a, 14, 15, 16, 17, 18, 19, 19a, 19b, 20, 20a, 21, and 22; 119B.02; 119B.025,
 121.19 subdivisions 1, 2, 3, and 4; 119B.03, subdivisions 1, 2, 3, 4, 5, 6, 6a, 6b, 8, 9, and 10;
 121.20 119B.035; 119B.04; 119B.05, subdivisions 1, 4, and 5; 119B.06, subdivisions 1, 2, and 3;
 121.21 119B.08, subdivisions 1, 2, and 3; 119B.09, subdivisions 1, 3, 4, 4a, 5, 6, 7, 8, 9, 9a, 10,
 121.22 11, 12, and 13; 119B.095; 119B.097; 119B.10, subdivisions 1, 2, and 3; 119B.105; 119B.11,
 121.23 subdivisions 1, 2a, 3, and 4; 119B.12, subdivisions 1 and 2; 119B.125; 119B.13, subdivisions
 121.24 1, 1a, 3, 3a, 3b, 3c, 4, 5, 6, and 7; 119B.14; 119B.15; and 119B.16, are repealed effective
 121.25 July 1, 2020.

121.26 (b) Minnesota Rules, parts 3400.0010; 3400.0020, subparts 1, 4, 5, 8, 9a, 10a, 12, 17a,
 121.27 18, 18a, 20, 24, 25, 26, 28, 29a, 31b, 32b, 33, 34a, 35, 37, 38, 38a, 38b, 39, 40, 40a, and
 121.28 44; 3400.0030; 3400.0035; 3400.0040, subparts 1, 3, 4, 5, 5a, 6a, 6b, 6c, 7, 8, 9, 10, 11, 12,
 121.29 13, 14, 15, 15a, 17, and 18; 3400.0060, subparts 2, 4, 5, 6, 6a, 7, 8, 9, and 10; 3400.0080,
 121.30 subparts 1, 1a, 1b, and 8; 3400.0090, subparts 1, 2, 3, and 4; 3400.0100, subparts 2a, 2b,
 121.31 2c, and 5; 3400.0110, subparts 1, 1a, 2, 2a, 3, 4a, 7, 8, 9, 10, and 11; 3400.0120, subparts
 121.32 1, 1a, 2, 2a, 3, and 5; 3400.0130, subparts 1, 1a, 2, 3, 3a, 3b, 5, 5a, and 7; 3400.0140, subparts
 121.33 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,

122.1 and 11; 3400.0180; 3400.0183, subparts 1, 2, and 5; 3400.0185; 3400.0187, subparts 1, 2,
 122.2 3, 4, and 6; 3400.0200; 3400.0220; 3400.0230, subpart 3; and 3400.0235, subparts 1, 2, 3,
 122.3 4, 5, and 6, are repealed are effective July 1, 2020.

122.4 (c) Laws 2017, First Special Session chapter 6, article 7, section 34, is repealed effective
 122.5 July 1, 2019.

122.6 **ARTICLE 3**

122.7 **CHEMICAL AND MENTAL HEALTH**

122.8 Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision
 122.9 to read:

122.10 Subd. 11. **Mental health data sharing.** Section 641.15, subdivision 3a, governs the
 122.11 sharing of data on prisoners who may have a mental illness or need services with county
 122.12 social service agencies or welfare system personnel.

122.13 Sec. 2. [245.4663] **OFFICER-INVOLVED COMMUNITY-BASED CARE**
 122.14 **COORDINATION GRANT PROGRAM.**

122.15 Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants
 122.16 to programs that provide officer-involved community-based care coordination services
 122.17 under section 256B.0625, subdivision 56a. The commissioner shall balance awarding grants
 122.18 to counties outside the metropolitan area and counties inside the metropolitan area.

122.19 (b) The commissioner shall provide outreach, technical assistance, and program
 122.20 development support to increase capacity of new and existing officer-involved
 122.21 community-based care coordination programs, particularly in areas where officer-involved
 122.22 community-based care coordination programs have not been established, especially in
 122.23 greater Minnesota.

122.24 (c) Funds appropriated for this section must be expended on activities described under
 122.25 subdivision 3, technical assistance, and capacity building, including the capacity to maximize
 122.26 revenue by billing services to available third-party reimbursement sources, in order to meet
 122.27 the greatest need on a statewide basis.

122.28 Subd. 2. **Eligibility.** An eligible applicant for an officer-involved community-based care
 122.29 coordination grant under subdivision 1, paragraph (a), is a county or tribe that operates or
 122.30 is prepared to implement an officer-involved community-based care coordination program.

122.31 Subd. 3. **Allowable grant activities.** Grant recipients may use grant funds for the costs
 122.32 of providing officer-involved community-based care coordination services that are not

123.1 otherwise covered under section 256B.0625, subdivision 56a, and for the cost of services
 123.2 for individuals not eligible for medical assistance.

123.3 Subd. 4. **Reporting.** (a) The commissioner shall report annually on the use of
 123.4 officer-involved community-based care coordination grants to the legislative committees
 123.5 with jurisdiction over human services by December 31, beginning in 2020. Each report shall
 123.6 include the name and location of the grant recipients, the amount of each grant, the services
 123.7 provided or planning activities conducted, and the number of individuals receiving services.
 123.8 The commissioner shall determine the form required for the reports and may specify
 123.9 additional reporting requirements.

123.10 (b) The reporting requirements under this subdivision are in addition to the reporting
 123.11 requirements under section 256B.0625, subdivision 56a, paragraph (e).

123.12 Sec. 3. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

123.13 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
 123.14 make grants from available appropriations to assist:

123.15 (1) counties;

123.16 (2) Indian tribes;

123.17 (3) children's collaboratives under section 124D.23 or 245.493; or

123.18 (4) mental health service providers.

123.19 (b) The following services are eligible for grants under this section:

123.20 (1) services to children with emotional disturbances as defined in section 245.4871,
 123.21 subdivision 15, and their families;

123.22 (2) transition services under section 245.4875, subdivision 8, for young adults under
 123.23 age 21 and their families;

123.24 (3) respite care services for children with severe emotional disturbances who are at risk
 123.25 of out-of-home placement, whether or not the child is receiving case management services;

123.26 (4) children's mental health crisis services;

123.27 (5) mental health services for people from cultural and ethnic minorities;

123.28 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

123.29 (7) services to promote and develop the capacity of providers to use evidence-based
 123.30 practices in providing children's mental health services;

124.1 (8) school-linked mental health services, including transportation for children receiving
 124.2 school-linked mental health services when school is not in session;

124.3 (9) building evidence-based mental health intervention capacity for children birth to age
 124.4 five;

124.5 (10) suicide prevention and counseling services that use text messaging statewide;

124.6 (11) mental health first aid training;

124.7 (12) training for parents, collaborative partners, and mental health providers on the
 124.8 impact of adverse childhood experiences and trauma and development of an interactive
 124.9 website to share information and strategies to promote resilience and prevent trauma;

124.10 (13) transition age services to develop or expand mental health treatment and supports
 124.11 for adolescents and young adults 26 years of age or younger;

124.12 (14) early childhood mental health consultation;

124.13 (15) evidence-based interventions for youth at risk of developing or experiencing a first
 124.14 episode of psychosis, and a public awareness campaign on the signs and symptoms of
 124.15 psychosis;

124.16 (16) psychiatric consultation for primary care practitioners; ~~and~~

124.17 (17) providers to begin operations and meet program requirements when establishing a
 124.18 new children's mental health program. These may be start-up grants; and

124.19 (18) promoting and developing a provider's capacity to deliver multigenerational mental
 124.20 health treatment and services.

124.21 (c) Services under paragraph (b) must be designed to help each child to function and
 124.22 remain with the child's family in the community and delivered consistent with the child's
 124.23 treatment plan. Transition services to eligible young adults under this paragraph must be
 124.24 designed to foster independent living in the community.

124.25 Sec. 4. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

124.26 Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human
 124.27 services shall establish by rule criteria to be used in determining the appropriate level of
 124.28 chemical dependency care for each recipient of public assistance seeking treatment for
 124.29 substance misuse or substance use disorder. Upon federal approval of a comprehensive
 124.30 assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding
 124.31 the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of

125.1 comprehensive assessments under section 254B.05 may determine and approve the
125.2 appropriate level of substance use disorder treatment for a recipient of public assistance.
125.3 The process for determining an individual's financial eligibility for the consolidated chemical
125.4 dependency treatment fund or determining an individual's enrollment in or eligibility for a
125.5 publicly subsidized health plan is not affected by the individual's choice to access a
125.6 comprehensive assessment for placement.

125.7 (b) The commissioner shall develop and implement a utilization review process for
125.8 publicly funded treatment placements to monitor and review the clinical appropriateness
125.9 and timeliness of all publicly funded placements in treatment.

125.10 (c) If a screen result is positive for alcohol or substance misuse, a brief screening for
125.11 alcohol or substance use disorder that is provided to a recipient of public assistance within
125.12 a primary care clinic, hospital, or other medical setting or school setting establishes medical
125.13 necessity and approval for an initial set of substance use disorder services identified in
125.14 section 254B.05, subdivision 5. The initial set of services approved for a recipient whose
125.15 screen result is positive may include four hours of individual or group substance use disorder
125.16 treatment, two hours of substance use disorder treatment coordination, or two hours of
125.17 substance use disorder peer support services provided by a qualified individual according
125.18 to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be
125.19 approved for additional treatment services.

125.20 **EFFECTIVE DATE.** Contingent upon federal approval, this section is effective July
125.21 1, 2019. The commissioner of human services shall notify the revisor of statutes when
125.22 federal approval is obtained or denied.

125.23 Sec. 5. Minnesota Statutes 2018, section 254A.19, is amended by adding a subdivision to
125.24 read:

125.25 Subd. 5. **Assessment via telemedicine.** Notwithstanding Minnesota Rules, part
125.26 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via telemedicine.

125.27 Sec. 6. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

125.28 Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency
125.29 treatment appropriation shall be placed in a special revenue account. ~~The commissioner~~
125.30 ~~shall annually transfer funds from the chemical dependency fund to pay for operation of~~
125.31 ~~the drug and alcohol abuse normative evaluation system and to pay for all costs incurred~~
125.32 ~~by adding two positions for licensing of chemical dependency treatment and rehabilitation~~
125.33 ~~programs located in hospitals for which funds are not otherwise appropriated. The remainder~~

126.1 of the money in the special revenue account must be used according to the requirements in
126.2 this chapter.

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

126.4 Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

126.5 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
126.6 dependency fund is limited to payments for services other than detoxification licensed under
126.7 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
126.8 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
126.9 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
126.10 services other than detoxification provided in another state that would be required to be
126.11 licensed as a chemical dependency program if the program were in the state. Out of state
126.12 vendors must also provide the commissioner with assurances that the program complies
126.13 substantially with state licensing requirements and possesses all licenses and certifications
126.14 required by the host state to provide chemical dependency treatment. Vendors receiving
126.15 payments from the chemical dependency fund must not require co-payment from a recipient
126.16 of benefits for services provided under this subdivision. The vendor is prohibited from using
126.17 the client's public benefits to offset the cost of services paid under this section. The vendor
126.18 shall not require the client to use public benefits for room or board costs. This includes but
126.19 is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP
126.20 benefits. Retention of SNAP benefits is a right of a client receiving services through the
126.21 consolidated chemical dependency treatment fund or through state contracted managed care
126.22 entities. Payment from the chemical dependency fund shall be made for necessary room
126.23 and board costs provided by vendors ~~certified according to~~ meeting the criteria under section
126.24 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health
126.25 according to sections 144.50 to 144.56 to a client who is:

126.26 (1) determined to meet the criteria for placement in a residential chemical dependency
126.27 treatment program according to rules adopted under section 254A.03, subdivision 3; and

126.28 (2) concurrently receiving a chemical dependency treatment service in a program licensed
126.29 by the commissioner and reimbursed by the chemical dependency fund.

126.30 (b) A county may, from its own resources, provide chemical dependency services for
126.31 which state payments are not made. A county may elect to use the same invoice procedures
126.32 and obtain the same state payment services as are used for chemical dependency services
126.33 for which state payments are made under this section if county payments are made to the
126.34 state in advance of state payments to vendors. When a county uses the state system for

127.1 payment, the commissioner shall make monthly billings to the county using the most recent
 127.2 available information to determine the anticipated services for which payments will be made
 127.3 in the coming month. Adjustment of any overestimate or underestimate based on actual
 127.4 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
 127.5 month.

127.6 (c) The commissioner shall coordinate chemical dependency services and determine
 127.7 whether there is a need for any proposed expansion of chemical dependency treatment
 127.8 services. ~~The commissioner shall deny vendor certification to any provider that has not~~
 127.9 ~~received prior approval from the commissioner for the creation of new programs or the~~
 127.10 ~~expansion of existing program capacity. The commissioner shall consider the provider's~~
 127.11 ~~capacity to obtain clients from outside the state based on plans, agreements, and previous~~
 127.12 ~~utilization history, when determining the need for new treatment services~~ The commissioner
 127.13 may deny vendor certification to a provider if the commissioner determines that the services
 127.14 currently available in the local area are sufficient to meet local need and that the addition
 127.15 of new services would be detrimental to individuals seeking these services.

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

127.17 Sec. 8. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

127.18 Subd. 4. **Division of costs.** (a) Except for services provided by a county under section
 127.19 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out
 127.20 of local money, pay the state for 22.95 percent of the cost of chemical dependency services,
 127.21 ~~including those~~ except that the county shall pay the state for ten percent of the nonfederal
 127.22 share of the cost of chemical dependency services provided to persons eligible for enrolled
 127.23 in medical assistance under chapter 256B, and ten percent of the cost of room and board
 127.24 services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may
 127.25 use the indigent hospitalization levy for treatment and hospital payments made under this
 127.26 section.

127.27 (b) 22.95 percent of any state collections from private or third-party pay, less 15 percent
 127.28 for the cost of payment and collections, must be distributed to the county that paid for a
 127.29 portion of the treatment under this section.

127.30 (c) ~~For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are~~
 127.31 ~~equal to 20.2 percent.~~

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

128.1 Sec. 9. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

128.2 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
128.3 Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under~~
128.4 ~~sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the~~
128.5 income standards of section 256B.056, subdivision 4, and are not enrolled in medical
128.6 assistance, are entitled to chemical dependency fund services. State money appropriated
128.7 for this paragraph must be placed in a separate account established for this purpose.

128.8 (b) Persons with dependent children who are determined to be in need of chemical
128.9 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
128.10 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
128.11 local agency to access needed treatment services. Treatment services must be appropriate
128.12 for the individual or family, which may include long-term care treatment or treatment in a
128.13 facility that allows the dependent children to stay in the treatment facility. The county shall
128.14 pay for out-of-home placement costs, if applicable.

128.15 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
128.16 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
128.17 (12).

128.18 **EFFECTIVE DATE.** This section is effective September 1, 2019.

128.19 Sec. 10. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

128.20 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
128.21 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

128.22 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
128.23 while residing in the facility and provide consequences for infractions of those rules;

128.24 (2) is determined to meet applicable health and safety requirements;

128.25 (3) is not a jail or prison;

128.26 (4) is not concurrently receiving funds under chapter 256I for the recipient;

128.27 (5) admits individuals who are 18 years of age or older;

128.28 (6) is registered as a board and lodging or lodging establishment according to section
128.29 157.17;

128.30 (7) has awake staff on site 24 hours per day;

129.1 (8) has staff who are at least 18 years of age and meet the requirements of section
129.2 245G.11, subdivision 1, paragraph (b);

129.3 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

129.4 (10) meets the requirements of section 245G.08, subdivision 5, if administering
129.5 medications to clients;

129.6 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
129.7 fraternization and the mandatory reporting requirements of section 626.557;

129.8 (12) documents coordination with the treatment provider to ensure compliance with
129.9 section 254B.03, subdivision 2;

129.10 (13) protects client funds and ensures freedom from exploitation by meeting the
129.11 provisions of section 245A.04, subdivision 13;

129.12 (14) has a grievance procedure that meets the requirements of section 245G.15,
129.13 subdivision 2; and

129.14 (15) has sleeping and bathroom facilities for men and women separated by a door that
129.15 is locked, has an alarm, or is supervised by awake staff.

129.16 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
129.17 paragraph (a), clauses (5) to (15).

129.18 (c) Licensed programs providing intensive residential treatment services or residential
129.19 crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors
129.20 of room and board and are exempt from paragraph (a), clauses (6) to (15).

129.21 **EFFECTIVE DATE.** This section is effective September 1, 2019.

129.22 Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

129.23 Subdivision 1. **State collections.** The commissioner is responsible for all collections
129.24 from persons determined to be partially responsible for the cost of care of an eligible person
129.25 receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may
129.26 initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid
129.27 cost of care. The commissioner may collect all third-party payments for chemical dependency
129.28 services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance
129.29 and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit~~
129.30 ~~in a dedicated account a percentage of collections to pay for the cost of operating the chemical~~
129.31 ~~dependency consolidated treatment fund invoice processing and vendor payment system,~~

130.1 ~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency
 130.2 fund.

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

130.4 Sec. 12. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

130.5 Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal~~
 130.6 ~~financial participation collections to a special revenue account.~~ The commissioner shall
 130.7 allocate 77.05 percent of patient payments and third-party payments to the special revenue
 130.8 account and 22.95 percent to the county financially responsible for the patient.

130.9 ~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account~~
 130.10 ~~shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility~~
 130.11 ~~shall be reduced from 22.95 percent to 20.2 percent.~~

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

130.13 Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

130.14 Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical
 130.15 or remedial care licensed and recognized under state law unless otherwise prohibited by
 130.16 law, ~~except licensed chemical dependency treatment programs or primary treatment or~~
 130.17 ~~extended care treatment units in hospitals that are covered under chapter 254B.~~ The
 130.18 ~~commissioner shall include chemical dependency services in the state medical assistance~~
 130.19 ~~plan for federal reporting purposes, but payment must be made under chapter 254B.~~ The
 130.20 commissioner shall publish in the State Register a list of elective surgeries that require a
 130.21 second medical opinion before medical assistance reimbursement, and the criteria and
 130.22 standards for deciding whether an elective surgery should require a second medical opinion.
 130.23 The list and criteria and standards are not subject to the requirements of sections 14.01 to
 130.24 14.69.

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

130.26 Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
 130.27 to read:

130.28 Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use
 130.29 disorder treatment services according to section 254B.05, subdivision 5, except for room
 130.30 and board.

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

131.1 Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to
131.2 read:

131.3 Subd. 56a. ~~Post-arrest~~ Officer-involved community-based service care
131.4 **coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based
131.5 service care coordination for an individual who:

131.6 (1) has ~~been identified as having~~ screened positive for benefiting from treatment for a
131.7 mental illness or substance use disorder using a screening tool approved by the commissioner;

131.8 (2) does not require the security of a public detention facility and is not considered an
131.9 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
131.10 435.1010;

131.11 (3) meets the eligibility requirements in section 256B.056; and

131.12 (4) has agreed to participate in ~~post-arrest~~ officer-involved community-based service
131.13 care coordination through a diversion contract in lieu of incarceration.

131.14 (b) ~~Post-arrest~~ Officer-involved community-based service care coordination means
131.15 navigating services to address a client's mental health, chemical health, social, economic,
131.16 and housing needs, or any other activity targeted at reducing the incidence of jail utilization
131.17 and connecting individuals with existing covered services available to them, including, but
131.18 not limited to, targeted case management, waiver case management, or care coordination.

131.19 (c) ~~Post-arrest~~ Officer-involved community-based service care coordination must be
131.20 provided by an individual who is an employee of a ~~county~~ or is under contract with a county,
131.21 or is an employee of or under contract with an Indian health service facility or facility owned
131.22 and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638
131.23 facility to provide ~~post-arrest~~ officer-involved community-based care coordination and is
131.24 qualified under one of the following criteria:

131.25 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,
131.26 clauses (1) to (6);

131.27 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
131.28 under the clinical supervision of a mental health professional; ~~or~~

131.29 (3) a certified peer specialist under section 256B.0615, working under the clinical
131.30 supervision of a mental health professional;

131.31 (4) an individual qualified as an alcohol and drug counselor under section 245G.11,
131.32 subdivision 5; or

132.1 (5) a recovery peer qualified under section 245G.11, subdivision 8, working under the
 132.2 supervision of an individual qualified as an alcohol and drug counselor under section
 132.3 245G.11, subdivision 5.

132.4 (d) Reimbursement is allowed for up to 60 days following the initial determination of
 132.5 eligibility.

132.6 (e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination
 132.7 shall annually report to the commissioner on the number of individuals served, and number
 132.8 of the community-based services that were accessed by recipients. The commissioner shall
 132.9 ensure that services and payments provided under ~~post-arrest~~ officer-involved
 132.10 community-based ~~service~~ care coordination do not duplicate services or payments provided
 132.11 under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

132.12 ~~(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for~~
 132.13 ~~post-arrest community-based service coordination services shall be provided by the county~~
 132.14 ~~providing the services, from sources other than federal funds or funds used to match other~~
 132.15 ~~federal funds.~~

132.16 Sec. 16. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

132.17 Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical
 132.18 assistance coverage of health home services for eligible individuals with chronic conditions
 132.19 who select a designated provider as the individual's health home.

132.20 (b) The commissioner shall implement this section in compliance with the requirements
 132.21 of the state option to provide health homes for enrollees with chronic conditions, as provided
 132.22 under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703
 132.23 and 3502. Terms used in this section have the meaning provided in that act.

132.24 (c) The commissioner shall establish health homes to serve populations with serious
 132.25 mental illness who meet the eligibility requirements described under subdivision 2, ~~clause~~
 132.26 ~~(4)~~. The health home services provided by health homes shall focus on both the behavioral
 132.27 and the physical health of these populations.

132.28 Sec. 17. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

132.29 Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home
 132.30 models in accordance with United States Code, title 42, section 1396w-4.

132.31 (b) An individual is eligible for health home services under this section if the individual
 132.32 is eligible for medical assistance under this chapter and has at least:

133.1 ~~(1) two chronic conditions;~~
 133.2 ~~(2) one chronic condition and is at risk of having a second chronic condition;~~
 133.3 ~~(3) one serious and persistent mental health condition; or~~
 133.4 ~~(4) a condition that meets the definition of mental illness as described in section 245.462,~~
 133.5 ~~subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871,~~
 133.6 ~~subdivision 15, clause (2); and has a current diagnostic assessment as defined in Minnesota~~
 133.7 ~~Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health~~
 133.8 ~~professional employed by or under contract with the behavioral health home. The~~
 133.9 commissioner shall establish criteria for determining continued eligibility.

133.10 Sec. 18. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

133.11 Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible
 133.12 individual may choose any designated provider. The commissioner shall establish designated
 133.13 providers to serve as health homes and provide the services described in subdivision 3 to
 133.14 individuals eligible under subdivision 2. The commissioner shall apply for grants as provided
 133.15 under section 3502 of the Patient Protection and Affordable Care Act to establish health
 133.16 homes and provide capitated payments to designated providers. For purposes of this section,
 133.17 "designated provider" means a provider, clinical practice or clinical group practice, rural
 133.18 clinic, community health center, community mental health center, or any other entity that
 133.19 is determined by the commissioner to be qualified to be a health home for eligible individuals.
 133.20 This determination must be based on documentation evidencing that the designated provider
 133.21 has the systems and infrastructure in place to provide health home services and satisfies the
 133.22 qualification standards established by the commissioner in consultation with stakeholders
 133.23 and approved by the Centers for Medicare and Medicaid Services.

133.24 ~~(b) The commissioner shall develop and implement certification standards for designated~~
 133.25 ~~providers under this subdivision.~~

133.26 Sec. 19. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 133.27 to read:

133.28 Subd. 9. Discharge criteria. (a) An individual may be discharged from behavioral health
 133.29 home services if:

133.30 (1) the behavioral health home services provider is unable to locate, contact, and engage
 133.31 the individual for a period of greater than three months after persistent efforts by the
 133.32 behavioral health home services provider; or

134.1 (2) the individual is unwilling to participate in behavioral health home services as
134.2 demonstrated by the individual's refusal to meet with the behavioral health home services
134.3 provider, or refusal to identify the individual's goals or the activities or support necessary
134.4 to achieve the individual's health and wellness goals.

134.5 (b) Before discharge from behavioral health home services, the behavioral health home
134.6 services provider must offer a face-to-face meeting with the individual, the individual's
134.7 identified supports, and the behavioral health home services provider to discuss options
134.8 available to the individual, including maintaining behavioral health home services.

134.9 Sec. 20. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
134.10 to read:

134.11 Subd. 10. Behavioral health home services provider requirements. A behavioral
134.12 health home services provider must:

134.13 (1) be an enrolled Minnesota Health Care Programs provider;

134.14 (2) provide a medical assistance covered primary care or behavioral health service;

134.15 (3) utilize an electronic health record;

134.16 (4) utilize an electronic patient registry that contains data elements required by the
134.17 commissioner;

134.18 (5) demonstrate the organization's capacity to administer screenings approved by the
134.19 commissioner for substance use disorder or alcohol and tobacco use;

134.20 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
134.21 to the individual's screening results;

134.22 (7) have policies and procedures to track referrals to ensure that the referral met the
134.23 individual's needs;

134.24 (8) conduct a brief needs assessment when an individual begins receiving behavioral
134.25 health home services. The brief needs assessment must be completed with input from the
134.26 individual and the individual's identified supports. The brief needs assessment must address
134.27 the individual's immediate safety and transportation needs and potential barriers to
134.28 participating in behavioral health home services;

134.29 (9) conduct a health wellness assessment within 60 days after intake that contains all
134.30 required elements identified by the commissioner;

135.1 (10) conduct a health action plan that contains all required elements identified by the
 135.2 commissioner within 90 days after intake and updated at least once every six months or
 135.3 more frequently if significant changes to an individual's needs or goals occur;

135.4 (11) agree to cooperate and participate with the state's monitoring and evaluation of
 135.5 behavioral health home services; and

135.6 (12) utilize the form approved by the commissioner to obtain the individual's written
 135.7 consent to begin receiving behavioral health home services.

135.8 Sec. 21. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 135.9 to read:

135.10 Subd. 11. **Provider training and practice transformation requirements.** (a) The
 135.11 behavioral health home services provider must ensure that all staff delivering behavioral
 135.12 health home services receive adequate preservice and ongoing training including:

135.13 (1) training approved by the commissioner that describes the goals and principles of
 135.14 behavioral health home services; and

135.15 (2) training on evidence-based practices to promote an individual's ability to successfully
 135.16 engage with medical, behavioral health, and social services to reach the individual's health
 135.17 and wellness goals.

135.18 (b) The behavioral health home services provider must ensure that staff are capable of
 135.19 implementing culturally responsive services as determined by the individual's culture,
 135.20 beliefs, values, and language as identified in the individual's health wellness assessment.

135.21 (c) The behavioral health home services provider must participate in the department's
 135.22 practice transformation activities to support continued skill and competency development
 135.23 in the provision of integrated medical, behavioral health, and social services.

135.24 Sec. 22. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 135.25 to read:

135.26 Subd. 12. **Staff qualifications.** (a) A behavioral health home services provider must
 135.27 maintain staff with required professional qualifications appropriate to the setting.

135.28 (b) If behavioral health home services are offered in a mental health setting, the
 135.29 integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice
 135.30 Act, sections 148.171 to 148.285.

136.1 (c) If behavioral health home services are offered in a primary care setting, the integration
 136.2 specialist must be a mental health professional as defined in section 245.462, subdivision
 136.3 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

136.4 (d) If behavioral health home services are offered in either a primary care setting or
 136.5 mental health setting, the systems navigator must be a mental health practitioner as defined
 136.6 in section 245.462, subdivision 17, or a community health worker as defined in section
 136.7 256B.0625, subdivision 49.

136.8 (e) If behavioral health home services are offered in either a primary care setting or
 136.9 mental health setting, the qualified health home specialist must be one of the following:

136.10 (1) a peer support specialist as defined in section 256B.0615;

136.11 (2) a family peer support specialist as defined in section 256B.0616;

136.12 (3) a case management associate as defined in section 245.462, subdivision 4, paragraph
 136.13 (g), or 245.4871, subdivision 4, paragraph (j);

136.14 (4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision
 136.15 5, clause (4);

136.16 (5) a community paramedic as defined in section 144E.28, subdivision 9;

136.17 (6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5);

136.18 or

136.19 (7) a community health worker as defined in section 256B.0625, subdivision 49.

136.20 Sec. 23. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 136.21 to read:

136.22 Subd. 13. **Service delivery standards.** (a) A behavioral health home services provider
 136.23 must meet the following service delivery standards:

136.24 (1) establish and maintain processes to support the coordination of an individual's primary
 136.25 care, behavioral health, and dental care;

136.26 (2) maintain a team-based model of care, including regular coordination and
 136.27 communication between behavioral health home services team members;

136.28 (3) use evidence-based practices that recognize and are tailored to the medical, social,
 136.29 economic, behavioral health, functional impairment, cultural, and environmental factors
 136.30 affecting the individual's health and health care choices;

- 137.1 (4) use person-centered planning practices to ensure the individual's health action plan
137.2 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
137.3 the individual and the individual's identified supports;
- 137.4 (5) use the patient registry to identify individuals and population subgroups requiring
137.5 specific levels or types of care and provide or refer the individual to needed treatment,
137.6 intervention, or service;
- 137.7 (6) utilize Department of Human Services Partner Portal to identify past and current
137.8 treatment or services and to identify potential gaps in care;
- 137.9 (7) deliver services consistent with standards for frequency and face-to-face contact as
137.10 required by the commissioner;
- 137.11 (8) ensure that all individuals receiving behavioral health home services have a diagnostic
137.12 assessment completed within six months of when the individual begins receiving behavioral
137.13 health home services;
- 137.14 (9) deliver services in locations and settings that meet the needs of the individual;
- 137.15 (10) provide a central point of contact to ensure that individuals and the individual's
137.16 identified supports can successfully navigate the array of services that impact the individual's
137.17 health and well-being;
- 137.18 (11) have capacity to assess an individual's readiness for change and the individual's
137.19 capacity to integrate new health care or community supports into the individual's life;
- 137.20 (12) offer or facilitate the provision of wellness and prevention education on
137.21 evidenced-based curriculums specific to the prevention and management of common chronic
137.22 conditions;
- 137.23 (13) help an individual set up and prepare for appointments, including accompanying
137.24 the individual to appointments as appropriate, and follow up with the individual after medical,
137.25 behavioral health, social service, or community support appointments;
- 137.26 (14) offer or facilitate the provision of health coaching related to chronic disease
137.27 management and how to navigate complex systems of care to the individual, the individual's
137.28 family, and identified supports;
- 137.29 (15) connect an individual, the individual's family, and identified supports to appropriate
137.30 support services that help the individual overcome access or service barriers, increase
137.31 self-sufficiency skills, and improve overall health;
- 137.32 (16) provide effective referrals and timely access to services; and

138.1 (17) establish a continuous quality improvement process for providing behavioral health
 138.2 home services.

138.3 (b) The behavioral health home services provider must also create a plan, in partnership
 138.4 with the individual and the individual's identified supports, to support the individual after
 138.5 discharge from a hospital, residential treatment program, or other setting. The plan must
 138.6 include protocols for:

138.7 (1) maintaining contact between the behavioral health home services team member and
 138.8 the individual and the individual's identified supports during and after discharge;

138.9 (2) linking the individual to new resources as needed;

138.10 (3) reestablishing the individual's existing services and community and social supports;
 138.11 and

138.12 (4) following up with appropriate entities to transfer or obtain the individual's service
 138.13 records as necessary for continued care.

138.14 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
 138.15 provider must:

138.16 (1) notify the behavioral health home services contact designated by the managed care
 138.17 plan within 30 days of when the individual begins behavioral health home services; and

138.18 (2) adhere to the managed care plan communication and coordination requirements
 138.19 described in the behavioral health home services manual.

138.20 (d) Before terminating behavioral health home services, the behavioral health home
 138.21 services provider must:

138.22 (1) provide a 60-day notice of termination of behavioral health home services to all
 138.23 individuals receiving behavioral health home services, the department, and managed care
 138.24 plans, if applicable; and

138.25 (2) refer individuals receiving behavioral health home services to a new behavioral
 138.26 health home services provider.

138.27 Sec. 24. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision
 138.28 to read:

138.29 Subd. 14. **Provider variances.** (a) The commissioner may grant a variance to specific
 138.30 requirements under subdivision 10, 11, 12, or 13 for a behavioral health home services
 138.31 provider according to this subdivision.

139.1 (b) The commissioner may grant a variance if the commissioner finds that (1) failure to
 139.2 grant the variance would result in hardship or injustice to the applicant, (2) the variance
 139.3 would be consistent with the public interest, and (3) the variance would not reduce the level
 139.4 of services provided to individuals served by the organization.

139.5 (c) The commissioner may grant a variance from one or more requirements to permit
 139.6 an applicant to offer behavioral health home services of a type or in a manner that is
 139.7 innovative if the commissioner finds that the variance does not impede the achievement of
 139.8 the criteria in subdivision 10, 11, 12, or 13 and may improve the behavioral health home
 139.9 services provided by the applicant.

139.10 (d) The commissioner's decision to grant or deny a variance request is final and not
 139.11 subject to appeal.

139.12 **Sec. 25. [256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

139.13 Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical
 139.14 assistance demonstration project to test reforms of Minnesota's substance use disorder
 139.15 treatment system to ensure individuals with substance use disorders have access to a full
 139.16 continuum of high quality care.

139.17 Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect
 139.18 to participate in the demonstration project and fulfill the requirements under subdivision 3.
 139.19 To participate, a provider must notify the commissioner of the provider's intent to participate
 139.20 in a format required by the commissioner and enroll as a demonstration project provider.

139.21 Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for
 139.22 participating providers that are consistent with the federal requirements of the demonstration
 139.23 project.

139.24 (b) Participating residential providers must obtain applicable licensure under chapters
 139.25 245F, 245G, or other applicable standards for the services provided and must:

139.26 (1) deliver services in accordance with American Society of Addiction Medicine (ASAM)
 139.27 standards;

139.28 (2) maintain formal patient referral arrangements with providers delivering step-up or
 139.29 step-down levels of care in accordance with ASAM standards; and

139.30 (3) provide or arrange for medication-assisted treatment services if requested by a client
 139.31 for whom an effective medication exists.

139.32 (c) Participating outpatient providers must be licensed and must:

140.1 (1) deliver services in accordance with ASAM standards; and

140.2 (2) maintain formal patient referral arrangements with providers delivering step-up or
140.3 step-down levels of care in accordance with ASAM standards.

140.4 (d) If the provider standards under chapter 245G or other applicable standards conflict
140.5 or are duplicative, the commissioner may grant variances to the standards if the variances
140.6 do not conflict with federal requirements. The commissioner shall publish service
140.7 components, service standards, and staffing requirements for participating providers that
140.8 are consistent with ASAM standards and federal requirements.

140.9 Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must
140.10 be increased for services provided to medical assistance enrollees.

140.11 (b) For substance use disorder services under section 254B.05, subdivision 5, paragraph
140.12 (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on
140.13 January 1, 2020.

140.14 (c) For substance use disorder services under section 254B.05, subdivision 5, paragraph
140.15 (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the
140.16 rates in effect on January 1, 2021.

140.17 Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement
140.18 the demonstration project under this section and to receive federal financial participation.

140.19 Sec. 26. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

140.20 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
140.21 entitled to a housing support payment to be made on the individual's behalf if the agency
140.22 has approved the setting where the individual will receive housing support and the individual
140.23 meets the requirements in paragraph (a), (b), or (c).

140.24 (a) The individual is aged, blind, or is over 18 years of age with a disability as determined
140.25 under the criteria used by the title II program of the Social Security Act, and meets the
140.26 resource restrictions and standards of section 256P.02, and the individual's countable income
140.27 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
140.28 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
140.29 income actually made available to a community spouse by an elderly waiver participant
140.30 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
140.31 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
140.32 provider of housing support in which the individual resides.

141.1 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
 141.2 paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the
 141.3 individual's resources are less than the standards specified by section 256P.02, and the
 141.4 individual's countable income as determined under section 256P.06, less the medical
 141.5 assistance personal needs allowance under section 256B.35 is less than the monthly rate
 141.6 specified in the agency's agreement with the provider of housing support in which the
 141.7 individual resides.

141.8 (c) ~~The individual receives licensed residential crisis stabilization services under section~~
 141.9 ~~256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive~~
 141.10 ~~concurrent housing support payments if receiving licensed residential crisis stabilization~~
 141.11 ~~services under section 256B.0624, subdivision 7. lacks a fixed, adequate, nighttime residence~~
 141.12 ~~upon discharge from a residential behavioral health treatment program, as determined by~~
 141.13 ~~treatment staff from the residential behavioral health treatment program. An individual is~~
 141.14 ~~eligible under this paragraph for up to three months, including a full or partial month from~~
 141.15 ~~the individual's move-in date at a setting approved for housing support following discharge~~
 141.16 ~~from treatment, plus two full months.~~

141.17 **EFFECTIVE DATE.** This section is effective September 1, 2019.

141.18 Sec. 27. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

141.19 Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision
 141.20 2a, providers shall ensure that participants have at a minimum:

141.21 (1) food preparation and service for three nutritional meals a day on site;

141.22 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

141.23 (3) housekeeping, including cleaning and lavatory supplies or service; and

141.24 (4) maintenance and operation of the building and grounds, including heat, water, garbage
 141.25 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
 141.26 and maintain equipment and facilities.

141.27 (b) Providers serving participants described in subdivision 1, paragraph (c), shall assist
 141.28 participants in applying for continuing housing support payments before the end of the
 141.29 eligibility period.

141.30 **EFFECTIVE DATE.** This section is effective September 1, 2019.

142.1 Sec. 28. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

142.2 Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board
142.3 payment to be made on behalf of an eligible individual is determined by subtracting the
142.4 individual's countable income under section 256I.04, subdivision 1, for a whole calendar
142.5 month from the room and board rate for that same month. The housing support payment is
142.6 determined by multiplying the housing support rate times the period of time the individual
142.7 was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

142.8 (b) For an individual with earned income under paragraph (a), prospective budgeting
142.9 must be used to determine the amount of the individual's payment for the following six-month
142.10 period. An increase in income shall not affect an individual's eligibility or payment amount
142.11 until the month following the reporting month. A decrease in income shall be effective the
142.12 first day of the month after the month in which the decrease is reported.

142.13 (c) For an individual who receives ~~licensed residential crisis stabilization services under~~
142.14 ~~section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04,
142.15 subdivision 1, paragraph (c), the ~~amount of~~ housing support payment amount is determined
142.16 by multiplying the housing support rate times the period of time the individual was a resident.

142.17 **EFFECTIVE DATE.** This section is effective September 1, 2019.

142.18 Sec. 29. Minnesota Statutes 2018, section 256K.45, subdivision 2, is amended to read:

142.19 Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report,
142.20 beginning in February 2015, which provides meaningful information to the legislative
142.21 committees having jurisdiction over the issue of homeless youth, that includes, but is not
142.22 limited to: (1) a list of the areas of the state with the greatest need for services and housing
142.23 for homeless youth, and the level and nature of the needs identified; (2) details about grants
142.24 made, including shelter-linked youth mental health grants under section 256K.46; (3) the
142.25 distribution of funds throughout the state based on population need; (4) follow-up
142.26 information, if available, on the status of homeless youth and whether they have stable
142.27 housing two years after services are provided; and (5) any other outcomes for populations
142.28 served to determine the effectiveness of the programs and use of funding.

142.29 Sec. 30. **[256K.46] SHELTER-LINKED YOUTH MENTAL HEALTH GRANT**
142.30 **PROGRAM.**

142.31 Subdivision 1. Establishment and authority. (a) The commissioner shall award grants
142.32 to provide mental health services to homeless or sexually exploited youth. To be eligible,

143.1 housing providers must partner with community-based mental health practitioners to provide
143.2 a continuum of mental health services, including short-term crisis response, support for
143.3 youth in longer-term housing settings, and ongoing relationships to support youth in other
143.4 housing arrangements in the community for homeless or sexually exploited youth.

143.5 (b) The commissioner shall consult with the commissioner of management and budget
143.6 to identify evidence-based mental health services for youth and give priority in awarding
143.7 grants to proposals that include evidence-based mental health services for youth.

143.8 (c) The commissioner may make two-year grants under this section.

143.9 (d) Money appropriated for this section must be expended on activities described under
143.10 subdivision 4, technical assistance, and capacity building to meet the greatest need on a
143.11 statewide basis. The commissioner shall provide outreach, technical assistance, and program
143.12 development support to increase capacity of new and existing service providers to better
143.13 meet needs statewide, particularly in areas where shelter-linked youth mental health services
143.14 have not been established, especially in greater Minnesota.

143.15 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

143.16 (b) "Commissioner" means the commissioner of human services, unless otherwise
143.17 indicated.

143.18 (c) "Housing provider" means a shelter, housing program, or other entity providing
143.19 services under the Homeless Youth Act in section 256K.45 and the Safe Harbor for Sexually
143.20 Exploited Youth Act in section 145.4716.

143.21 (d) "Mental health practitioner" has the meaning given in section 245.462, subdivision
143.22 17.

143.23 (e) "Youth" has the meanings given for "homeless youth," "youth at risk for
143.24 homelessness," and "runaway" in section 256K.45, subdivision 1a, "sexually exploited
143.25 youth" in section 260C.007, subdivision 31, and "youth eligible for services" in section
143.26 145.4716, subdivision 3.

143.27 Subd. 3. **Eligibility.** An eligible applicant for shelter-linked youth mental health grants
143.28 under subdivision 1 is a housing provider that:

143.29 (1) demonstrates that the provider received targeted trauma training focused on sexual
143.30 exploitation and adolescent experiences of homelessness; and

144.1 (2) partners with a community-based mental health practitioner who has demonstrated
144.2 experience or access to training regarding adolescent development and trauma-informed
144.3 responses.

144.4 Subd. 4. **Allowable grant activities.** (a) Grant recipients may conduct the following
144.5 activities with community-based mental health practitioners:

144.6 (1) develop programming to prepare youth to receive mental health services;

144.7 (2) provide on-site mental health services, including group skills and therapy sessions.

144.8 Grant recipients are encouraged to use evidence-based mental health services;

144.9 (3) provide mental health case management, as defined in section 256B.0625, subdivision
144.10 20; and

144.11 (4) consult, train, and educate housing provider staff regarding mental health. Grant
144.12 recipients are encouraged to provide staff with access to a mental health crisis line 24 hours
144.13 a day, seven days a week.

144.14 (b) Only after promoting and assisting participants with obtaining health insurance
144.15 coverage for which the participant is eligible, and only after mental health practitioners bill
144.16 covered services to medical assistance or health plan companies, grant recipients may use
144.17 grant funds to fill gaps in insurance coverage for mental health services.

144.18 (c) Grant funds may be used for purchasing equipment, connection charges, on-site
144.19 coordination, set-up fees, and site fees to deliver shelter-linked youth mental health services
144.20 defined in this subdivision via telemedicine consistent with section 256B.0625, subdivision
144.21 3b.

144.22 Subd. 5. **Reporting.** Grant recipients shall report annually on the use of shelter-linked
144.23 youth mental health grants to the commissioner by December 31, beginning in 2020. Each
144.24 report shall include the name and location of the grant recipient, the amount of each grant,
144.25 the youth mental health services provided, and the number of youth receiving services. The
144.26 commissioner shall determine the form required for the reports and may specify additional
144.27 reporting requirements. The commissioner shall include the shelter-linked youth mental
144.28 health services program in the biennial report required under section 256K.45, subdivision
144.29 2.

144.30 Sec. 31. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

144.31 Subd. 3a. **Intake procedure; approved mental health screening; data sharing.** As
144.32 part of its intake procedure for new prisoners, the sheriff or local corrections shall use a

145.1 mental health screening tool approved by the commissioner of corrections, in consultation
 145.2 with the commissioner of human services and local corrections staff, to identify persons
 145.3 who may have a mental illness. Notwithstanding section 13.85, the sheriff or local corrections
 145.4 may share the names of persons who have screened positive for or may have a mental illness
 145.5 with the local county social services agency. The sheriff or local corrections may refer a
 145.6 person to county personnel of the welfare system, as defined in section 13.46, subdivision
 145.7 1, paragraph (c), in order to arrange for services upon discharge and may share private data
 145.8 on the individual as necessary to:

145.9 (1) provide assistance in filling out an application for medical assistance or
 145.10 MinnesotaCare;

145.11 (2) make a referral for case management as provided under section 245.467, subdivision
 145.12 4;

145.13 (3) provide assistance in obtaining a state photo identification;

145.14 (4) secure a timely appointment with a psychiatrist or other appropriate community
 145.15 mental health provider;

145.16 (5) provide prescriptions for a 30-day supply of all necessary medications; or

145.17 (6) provide for behavioral health service coordination.

145.18 Sec. 32. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective
 145.19 date, is amended to read:

145.20 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
 145.21 through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

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

145.23 Sec. 33. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective
 145.24 date, is amended to read:

145.25 **EFFECTIVE DATE.** This section is effective for services provided on July 1, 2017,
 145.26 through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

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

146.1 Sec. 34. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER**
146.2 **TREATMENT PROGRAM SYSTEMS IMPROVEMENT.**

146.3 The commissioner of human services, in consultation with counties, tribes, managed
146.4 care organizations, substance use disorder treatment associations, and other relevant
146.5 stakeholders, shall develop a plan, proposed timeline, and summary of necessary resources
146.6 to make systems improvements to minimize the regulatory paperwork for substance use
146.7 disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under
146.8 Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, parts 2960.0580 to
146.9 2960.0700. The plan shall include procedures to ensure that continued input from all
146.10 stakeholders is considered and that the planned systems improvements maximize client
146.11 benefits and utility for providers, regulatory agencies, and payers.

146.12 Sec. 35. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
146.13 **PERSON-CENTERED TELEPRESENCE PLATFORM EXPANSION.**

146.14 (a) By January 15, 2020, the commissioner of human services shall develop and provide
146.15 to the chairs and ranking minority members of the legislative committees with jurisdiction
146.16 over health and human services a proposal, including a timeline, a summary of necessary
146.17 resources, and any necessary legislative changes, to adapt and expand statewide, a common,
146.18 interoperable, person-centered telepresence platform for delivering behavioral health and
146.19 other health care services.

146.20 (b) In developing the proposal, the commissioner shall consult with the commissioners
146.21 of management and budget, MN.IT services, corrections, health, and education, and other
146.22 relevant stakeholders including but not limited to county services agencies in the areas of
146.23 human services, health, and corrections or law enforcement from counties outside the
146.24 metropolitan area; public health representatives; behavioral health and primary care service
146.25 providers, including providers from outside the metropolitan area; representatives of the
146.26 Minnesota School Boards Association; representatives of the Minnesota Hospital Association,
146.27 including rural hospital emergency departments; community mental health centers; adolescent
146.28 treatment centers; child advocacy centers; and the domestic abuse perpetrator program.

146.29 (c) In developing the proposal, the commissioner shall:

146.30 (1) explore opportunities for improving behavioral health and other health care service
146.31 delivery through the use of a common interoperable person-centered telepresence platform
146.32 that provides connectivity and technical support to potential users;

147.1 (2) review and coordinate state and local innovation initiatives and investments designed
147.2 to leverage telepresence connectivity and collaboration;

147.3 (3) identify necessary standards and capabilities for a common interoperable telepresence
147.4 platform;

147.5 (4) identify barriers to providing telepresence technology, including limited availability
147.6 of bandwidth, limitations in providing certain services via telepresence, and broadband
147.7 infrastructure needs;

147.8 (5) make recommendations for governance to ensure the person-centered responsiveness
147.9 of a common telepresence platform;

147.10 (6) develop incentives for ongoing innovation by service providers in Minnesota's health
147.11 and human services systems;

147.12 (7) evaluate the use of vendors to provide a common telepresence platform that meets
147.13 identified standards and capabilities;

147.14 (8) identify sustainable financial support for a common telepresence platform, including
147.15 infrastructure costs and start-up costs for potential users; and

147.16 (9) identify the benefits to the state, political subdivisions, tribal governments, and
147.17 constituents from using a common person-centered telepresence platform for delivering
147.18 behavioral health services.

147.19 **Sec. 36. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
147.20 **IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

147.21 (a) The commissioner of human services, in collaboration with the commissioner of
147.22 education, representatives from the education community, mental health providers, and
147.23 advocates, shall assess the school-linked mental health grant program under Minnesota
147.24 Statutes, section 245.4901, and develop recommendations for improvements. The assessment
147.25 must include but is not limited to the following:

147.26 (1) promoting stability among current grantees and school partners;

147.27 (2) assessing the minimum number of full-time equivalents needed per school site to
147.28 effectively carry out the program;

147.29 (3) developing a funding formula that promotes sustainability and consistency across
147.30 grant cycles;

147.31 (4) reviewing current data collection and evaluation; and

148.1 (5) analyzing the impact on outcomes when a school has a school-linked mental health
148.2 program, a multi-tier system of supports, and sufficient school support personnel to meet
148.3 the needs of students.

148.4 (b) The commissioner shall provide a report of the findings of the assessment and
148.5 recommendations, including any necessary statutory changes, to the legislative committees
148.6 with jurisdiction over mental health and education by January 15, 2020.

148.7 **Sec. 37. OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION;**
148.8 **PLANNING GRANTS.**

148.9 In fiscal year 2020, the commissioner shall award up to ten planning grants of up to
148.10 \$10,000 available to counties and tribes to establish new officer-involved community-based
148.11 care coordination programs. An eligible applicant for a planning grant under this section is
148.12 a county or tribe that does not have a fully functioning officer-involved community-based
148.13 care coordination program and has not yet taken steps to implement an officer-involved
148.14 community-based care coordination program. Planning grant recipients may use grant funds
148.15 for the start-up costs of a new officer-involved community-based care coordination program,
148.16 including data platform design, data collection, and quarterly reporting.

148.17 **Sec. 38. COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

148.18 Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task
148.19 Force is established to evaluate and study community competency restoration programs and
148.20 develop recommendations to address the needs of individuals deemed incompetent to stand
148.21 trial.

148.22 Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists
148.23 of the following members, appointed as follows:

148.24 (1) a representative appointed by the governor's office;

148.25 (2) the commissioner of human services or designee;

148.26 (3) the commissioner of corrections or designee;

148.27 (4) a representative from direct care and treatment services with experience in competency
148.28 evaluations, appointed by the commissioner of human services;

148.29 (5) a representative appointed by the designated State Protection and Advocacy system;

148.30 (6) the ombudsman for mental health and developmental disabilities;

148.31 (7) a representative appointed by the Minnesota Hospital Association;

- 149.1 (8) a representative appointed by the Association of Minnesota Counties;
- 149.2 (9) two representatives appointed by the Minnesota Association of County Social Service
- 149.3 Administrators: one from the seven-county metropolitan area, as defined under Minnesota
- 149.4 Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan
- 149.5 area;
- 149.6 (10) a representative appointed by the Board of Public Defense;
- 149.7 (11) a representative appointed by the Minnesota County Attorney Association;
- 149.8 (12) a representative appointed by the Chiefs of Police;
- 149.9 (13) a representative appointed by the Minnesota Psychiatric Society;
- 149.10 (14) a representative appointed by the Minnesota Psychological Association;
- 149.11 (15) a representative appointed by the State Court Administrator;
- 149.12 (16) a representative appointed by the Minnesota Association of Community Mental
- 149.13 Health Programs;
- 149.14 (17) a representative appointed by the Minnesota Sheriff's Association;
- 149.15 (18) a representative appointed by the Sentencing Commission;
- 149.16 (19) a jail administrator appointed by the commissioner of corrections;
- 149.17 (20) a representative from an organization providing reentry services appointed by the
- 149.18 commissioner of corrections;
- 149.19 (21) a representative from a mental health advocacy organization appointed by the
- 149.20 commissioner of human services;
- 149.21 (22) a person with direct experience with competency restoration appointed by the
- 149.22 commissioner of human services;
- 149.23 (23) representatives from organizations representing racial and ethnic groups
- 149.24 overrepresented in the justice system appointed by the commissioner of corrections; and
- 149.25 (24) a crime victim appointed by the commissioner of corrections.
- 149.26 (b) Appointments to the task force must be made no later than July 15, 2019, and members
- 149.27 of the task force may be compensated as provided under Minnesota Statutes, section 15.059,
- 149.28 subdivision 3.
- 149.29 Subd. 3. **Duties.** The task force must:

150.1 (1) identify current services and resources available for individuals in the criminal justice
150.2 system who have been found incompetent to stand trial;

150.3 (2) analyze current trends of competency referrals by county and the impact of any
150.4 diversion projects or stepping-up initiatives;

150.5 (3) analyze selected case reviews and other data to identify risk levels of those individuals,
150.6 service usage, housing status, and health insurance status prior to being jailed;

150.7 (4) research how other states address this issue, including funding and structure of
150.8 community competency restoration programs, and jail-based programs; and

150.9 (5) develop recommendations to address the growing number of individuals deemed
150.10 incompetent to stand trial including increasing prevention and diversion efforts, providing
150.11 a timely process for reducing the amount of time individuals remain in the criminal justice
150.12 system, determining how to provide and fund competency restoration services in the
150.13 community, and defining the role of the counties and state in providing competency
150.14 restoration.

150.15 Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene
150.16 the first meeting of the task force no later than August 1, 2019.

150.17 (b) The task force must elect a chair and vice-chair from among its members and may
150.18 elect other officers as necessary.

150.19 (c) The task force is subject to the Minnesota Open Meeting Law under Minnesota
150.20 Statutes, chapter 13D.

150.21 Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance
150.22 to support the task force's work.

150.23 (b) The task force may utilize the expertise of the Council of State Governments Justice
150.24 Center.

150.25 Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report
150.26 on its progress and findings to the chairs and ranking minority members of the legislative
150.27 committees with jurisdiction over mental health and corrections.

150.28 (b) By February 1, 2021, the task force must submit a written report including
150.29 recommendations to address the growing number of individuals deemed incompetent to
150.30 stand trial to the chairs and ranking minority members of the legislative committees with
150.31 jurisdiction over mental health and corrections.

151.1 Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision
151.2 6, paragraph (b), or February 1, 2021, whichever is later.

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

151.4 Sec. 39. **SPECIALIZED MENTAL HEALTH COMMUNITY SUPERVISION PILOT**
151.5 **PROJECT.**

151.6 Subdivision 1. **Authorization.** The commissioner of human services shall award a grant
151.7 to Anoka County to develop and implement a pilot project from July 1, 2019, to June 30,
151.8 2021, to evaluate the impact of a coordinated, multidisciplinary service delivery approach
151.9 for offenders with mental illness who are on probation, parole, supervised release, or pretrial
151.10 status in Anoka County.

151.11 Subd. 2. **Pilot project goals and design.** (a) The pilot project must provide enhanced
151.12 assessment, case management, treatment services, and community supervision for offenders
151.13 with mental illness who have symptoms or behavior resulting in heightened risk to harm
151.14 themselves or others, to recidivate, to commit violations of supervision, or to face
151.15 incarceration or reincarceration.

151.16 (b) The goals of the pilot project are to:

151.17 (1) improve mental health service delivery and supervision coordination through
151.18 establishment of a multidisciplinary caseload management team that must include at least
151.19 one probation officer and social services professional who share case management
151.20 responsibilities;

151.21 (2) provide expedited assessment, diagnosis, and community-based treatment and
151.22 programming for acute symptom and behavior management;

151.23 (3) enhance community supervision through a specialized caseload and team specifically
151.24 trained to work with individuals with mental illness;

151.25 (4) offer community-based mental health treatment and programming alternatives to
151.26 incarceration if available and appropriate;

151.27 (5) reduce incarceration related to unmanaged mental illness and technical violations;

151.28 (6) eliminate or reduce duplication of services between county social services and
151.29 corrections; and

151.30 (7) improve collaboration among, and reduce barriers between, criminal justice system
151.31 partners, county social services, and community service providers.

152.1 Subd. 3. **Target population.** The target population of the pilot project is:

152.2 (1) adult offenders on probation, parole, supervised release, or pretrial status in Anoka
 152.3 County who have been assessed with significant or unmanaged mental illness or acute
 152.4 symptoms that pose a risk to harm themselves or others, or increase their risk to recidivate
 152.5 or commit technical violations of supervision;

152.6 (2) adult offenders who receive county social service case management for mental illness
 152.7 while under correctional supervision in Anoka County; and

152.8 (3) adult offenders incarcerated in jail in Anoka County who have significant or
 152.9 unmanaged mental illness and may be safely treated in a community setting under
 152.10 correctional supervision.

152.11 Subd. 4. **Evaluation and report.** By October 1, 2021, Anoka County must report to the
 152.12 commissioner of human services on the impact and outcomes of the project.

152.13 Sec. 40. **REPEALER.**

152.14 (a) Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

152.15 (b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

152.16 **ARTICLE 4**

152.17 **CONTINUING CARE FOR OLDER ADULTS**

152.18 Section 1. Minnesota Statutes 2018, section 144A.073, is amended by adding a subdivision
 152.19 to read:

152.20 Subd. 16. **Moratorium exception funding.** In fiscal year 2020, the commissioner may
 152.21 approve moratorium exception projects under this section for which the full annualized state
 152.22 share of medical assistance costs does not exceed \$2,000,000 plus any carryover of previous
 152.23 appropriations for this purpose.

152.24 Sec. 2. Minnesota Statutes 2018, section 256R.25, is amended to read:

152.25 **256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.**

152.26 (a) The payment rate for external fixed costs is the sum of the amounts in paragraphs
 152.27 (b) to ~~(n)~~ (o).

152.28 (b) For a facility licensed as a nursing home, the portion related to the provider surcharge
 152.29 under section 256.9657 is equal to \$8.86 per resident day. For a facility licensed as both a
 152.30 nursing home and a boarding care home, the portion related to the provider surcharge under

153.1 section 256.9657 is equal to \$8.86 per resident day multiplied by the result of its number
153.2 of nursing home beds divided by its total number of licensed beds.

153.3 (c) The portion related to the licensure fee under section 144.122, paragraph (d), is the
153.4 amount of the fee divided by the sum of the facility's resident days.

153.5 (d) The portion related to development and education of resident and family advisory
153.6 councils under section 144A.33 is \$5 per resident day divided by 365.

153.7 (e) The portion related to scholarships is determined under section 256R.37.

153.8 (f) The portion related to planned closure rate adjustments is as determined under section
153.9 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

153.10 (g) The portion related to consolidation rate adjustments shall be as determined under
153.11 section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

153.12 (h) The portion related to single-bed room incentives is as determined under section
153.13 256R.41.

153.14 (i) The portions related to real estate taxes, special assessments, and payments made in
153.15 lieu of real estate taxes directly identified or allocated to the nursing facility are the actual
153.16 amounts divided by the sum of the facility's resident days. Allowable costs under this
153.17 paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate
153.18 taxes shall not exceed the amount which the nursing facility would have paid to a city or
153.19 township and county for fire, police, sanitation services, and road maintenance costs had
153.20 real estate taxes been levied on that property for those purposes.

153.21 (j) The portion related to employer health insurance costs is the allowable costs divided
153.22 by the sum of the facility's resident days.

153.23 (k) The portion related to the Public Employees Retirement Association is actual costs
153.24 divided by the sum of the facility's resident days.

153.25 (l) The portion related to quality improvement incentive payment rate adjustments is
153.26 the amount determined under section 256R.39.

153.27 (m) The portion related to performance-based incentive payments is the amount
153.28 determined under section 256R.38.

153.29 (n) The portion related to special dietary needs is the amount determined under section
153.30 256R.51.

153.31 (o) The portion related to the rate adjustments for border city facilities is the amount
153.32 determined under section 256R.481.

154.1 **Sec. 3. [256R.481] RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.**

154.2 (a) The commissioner shall allow each nonprofit nursing facility located within the
 154.3 boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once
 154.4 annually for a rate add-on to the facility's external fixed costs payment rate.

154.5 (b) A facility seeking an add-on to its external fixed costs payment rate under this section
 154.6 must apply annually to the commissioner to receive the add-on. A facility must submit the
 154.7 application within 60 calendar days of the effective date of any add-on under this section.
 154.8 The commissioner may waive the deadlines required by this paragraph under extraordinary
 154.9 circumstances.

154.10 (c) The commissioner shall provide the add-on to each eligible facility that applies by
 154.11 the application deadline.

154.12 (d) The add-on to the external fixed costs payment rate is the difference on January 1
 154.13 of the median total payment rate for case mix classification PA1 of the nonprofit facilities
 154.14 located in an adjacent city in another state and in cities contiguous to the adjacent city minus
 154.15 the eligible nursing facility's total payment rate for case mix classification PA1 as determined
 154.16 under section 256R.22, subdivision 4.

154.17 **EFFECTIVE DATE.** The add-on to the external fixed costs payment rate described in
 154.18 Minnesota Statutes, section 256R.481, is available for the rate years beginning on and after
 154.19 January 1, 2021.

154.20 **Sec. 4. REPEALER.**

154.21 Minnesota Statutes 2018, section 256R.53, subdivision 2, is repealed effective January
 154.22 1, 2021.

154.23 **ARTICLE 5**

154.24 **DISABILITY SERVICES**

154.25 Section 1. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

154.26 **Subd. 7. Licensing moratorium.** (a) The commissioner shall not issue an initial license
 154.27 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
 154.28 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
 154.29 for a physical location that will not be the primary residence of the license holder for the
 154.30 entire period of licensure. If a license is issued during this moratorium, and the license
 154.31 holder changes the license holder's primary residence away from the physical location of
 154.32 the foster care license, the commissioner shall revoke the license according to section

155.1 245A.07. The commissioner shall not issue an initial license for a community residential
155.2 setting licensed under chapter 245D. When approving an exception under this paragraph,
155.3 the commissioner shall consider the resource need determination process in paragraph (h),
155.4 the availability of foster care licensed beds in the geographic area in which the licensee
155.5 seeks to operate, the results of a person's choices during their annual assessment and service
155.6 plan review, and the recommendation of the local county board. The determination by the
155.7 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

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

155.13 (3) new foster care licenses or community residential setting licenses determined to be
155.14 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
155.15 or regional treatment center; restructuring of state-operated services that limits the capacity
155.16 of state-operated facilities; or allowing movement to the community for people who no
155.17 longer require the level of care provided in state-operated facilities as provided under section
155.18 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

155.21 (5) new foster care licenses or community residential setting licenses determined to be
155.22 needed by the commissioner for the transition of people from personal care assistance to
155.23 the home and community-based services;

155.24 (6) new foster care licenses or community residential setting licenses determined to be
155.25 needed by the commissioner for the transition of people from the residential care waiver
155.26 services to foster care services. This exception applies only when:

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

155.30 (ii) the person's foster care services are less than or equal to the cost of the person's
155.31 services delivered in the residential care waiver service setting as determined by the lead
155.32 agency; or

156.1 (7) new foster care licenses or community residential setting licenses for people receiving
156.2 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
156.3 for which a license is required. This exception does not apply to people living in their own
156.4 home. For purposes of this clause, there is a presumption that a foster care or community
156.5 residential setting license is required for services provided to three or more people in a
156.6 dwelling unit when the setting is controlled by the provider. A license holder subject to this
156.7 exception may rebut the presumption that a license is required by seeking a reconsideration
156.8 of the commissioner's determination. The commissioner's disposition of a request for
156.9 reconsideration is final and not subject to appeal under chapter 14. The exception is available
156.10 until June 30, ~~2018~~ 2019. This exception is available when:

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

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

156.17 (8) a vacancy in a setting granted an exception under clause (7), created between January
156.18 1, 2017, and the date of the exception request, by the departure of a person receiving services
156.19 under chapter 245D and residing in the unlicensed setting between January 1, 2017, and
156.20 May 1, 2017. This exception is available when the lead agency provides documentation to
156.21 the commissioner on the eligibility criteria being met. This exception is available until June
156.22 30, 2019.

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

156.29 (c) When an adult resident ~~served by the program moves out of a~~ for any reason
156.30 permanently vacates a bed in an adult foster care home that is not the primary residence of
156.31 the license holder according to section 256B.49, subdivision 15, paragraph (f), or the a bed
156.32 in an adult community residential setting, the county shall immediately inform the
156.33 Department of Human Services Licensing Division commissioner. Within six months of
156.34 the second bed being permanently vacated, the department may commissioner shall decrease

157.1 the statewide licensed capacity for adult foster care settings by one bed for every two beds
157.2 vacated.

157.3 (d) Residential settings that would otherwise be subject to the decreased license capacity
157.4 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
157.5 residents whose primary diagnosis is mental illness and the license holder is certified under
157.6 the requirements in subdivision 6a or section 245D.33.

157.7 (e) A resource need determination process, managed at the state level, using the available
157.8 reports required by section 144A.351, and other data and information shall be used to
157.9 determine where the reduced capacity determined under section 256B.493 will be
157.10 implemented. The commissioner shall consult with the stakeholders described in section
157.11 144A.351, and employ a variety of methods to improve the state's capacity to meet the
157.12 informed decisions of those people who want to move out of corporate foster care or
157.13 community residential settings, long-term service needs within budgetary limits, including
157.14 seeking proposals from service providers or lead agencies to change service type, capacity,
157.15 or location to improve services, increase the independence of residents, and better meet
157.16 needs identified by the long-term services and supports reports and statewide data and
157.17 information.

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

157.26 (g) License holders of foster care homes identified under paragraph (f) that are not the
157.27 primary residence of the license holder and that also provide services in the foster care home
157.28 that are covered by a federally approved home and community-based services waiver, as
157.29 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
157.30 licensing division that the license holder provides or intends to provide these waiver-funded
157.31 services.

157.32 (h) The commissioner may adjust capacity to address needs identified in section
157.33 144A.351. Under this authority, the commissioner may approve new licensed settings or
157.34 delicense existing settings. Delicensing of settings will be accomplished through a process

158.1 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
158.2 information and data on capacity of licensed long-term services and supports, actions taken
158.3 under the subdivision to manage statewide long-term services and supports resources, and
158.4 any recommendations for change to the legislative committees with jurisdiction over the
158.5 health and human services budget.

158.6 (i) The commissioner must notify a license holder when its corporate foster care or
158.7 community residential setting licensed beds are reduced under this section. The notice of
158.8 reduction of licensed beds must be in writing and delivered to the license holder by certified
158.9 mail or personal service. The notice must state why the licensed beds are reduced and must
158.10 inform the license holder of its right to request reconsideration by the commissioner. The
158.11 license holder's request for reconsideration must be in writing. If mailed, the request for
158.12 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
158.13 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
158.14 reconsideration is made by personal service, it must be received by the commissioner within
158.15 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

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

158.25 **EFFECTIVE DATE.** This section is effective July 1, 2019, except the amendment to
158.26 paragraph (a) adding clause (8) is effective retroactively from July 1, 2018, and applies to
158.27 exception requests made on or after that date.

158.28 Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

158.29 Subd. 2a. **Adult foster care and community residential setting license capacity.** (a)
158.30 The commissioner shall issue adult foster care and community residential setting licenses
158.31 with a maximum licensed capacity of four beds, including nonstaff roomers and boarders,
158.32 except that the commissioner may issue a license with a capacity of five up to six beds,
158.33 including roomers and boarders, according to paragraphs (b) to (g).

159.1 (b) The license holder may have a maximum license capacity of five if all persons in
159.2 care are age 55 or over and do not have a serious and persistent mental illness or a
159.3 developmental disability.

159.4 (c) The commissioner may grant variances to paragraph (b) to allow a facility with a
159.5 licensed capacity of up to five persons to admit an individual under the age of 55 if the
159.6 variance complies with section 245A.04, subdivision 9, and approval of the variance is
159.7 recommended by the county in which the licensed facility is located.

159.8 (d) The commissioner may grant variances to paragraph (a) to allow the use of an
159.9 additional bed, up to five, for emergency crisis services for a person with serious and
159.10 persistent mental illness or a developmental disability, regardless of age, if the variance
159.11 complies with section 245A.04, subdivision 9, and approval of the variance is recommended
159.12 by the county in which the licensed facility is located.

159.13 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of an
159.14 additional bed, up to five, for respite services, as defined in section 245A.02, for persons
159.15 with disabilities, regardless of age, if the variance complies with sections 245A.03,
159.16 subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended
159.17 by the county in which the licensed facility is located. Respite care may be provided under
159.18 the following conditions:

159.19 (1) staffing ratios cannot be reduced below the approved level for the individuals being
159.20 served in the home on a permanent basis;

159.21 (2) no more than two different individuals can be accepted for respite services in any
159.22 calendar month and the total respite days may not exceed 120 days per program in any
159.23 calendar year;

159.24 (3) the person receiving respite services must have his or her own bedroom, which could
159.25 be used for alternative purposes when not used as a respite bedroom, and cannot be the
159.26 room of another person who lives in the facility; and

159.27 (4) individuals living in the facility must be notified when the variance is approved. The
159.28 provider must give 60 days' notice in writing to the residents and their legal representatives
159.29 prior to accepting the first respite placement. Notice must be given to residents at least two
159.30 days prior to service initiation, or as soon as the license holder is able if they receive notice
159.31 of the need for respite less than two days prior to initiation, each time a respite client will
159.32 be served, unless the requirement for this notice is waived by the resident or legal guardian.

160.1 (f) The commissioner may issue an adult foster care or community residential setting
160.2 license with a capacity of ~~five~~ six adults if the ~~fifth bed does~~ and sixth beds do not increase
160.3 the overall statewide capacity of licensed adult foster care or community residential setting
160.4 beds in homes that are not the primary residence of the license holder, as identified in a plan
160.5 submitted to the commissioner by the county, when the capacity is recommended by the
160.6 county licensing agency of the county in which the facility is located and if the
160.7 recommendation verifies that:

160.8 (1) the facility meets the physical environment requirements in the adult foster care
160.9 licensing rule;

160.10 (2) the ~~five-bed~~ or six-bed living arrangement is specified for each resident in the
160.11 resident's:

160.12 (i) individualized plan of care;

160.13 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

160.14 (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
160.15 subpart 19, if required;

160.16 (3) the license holder obtains written and signed informed consent from each resident
160.17 or resident's legal representative documenting the resident's informed choice to remain
160.18 living in the home and that the resident's refusal to consent would not have resulted in
160.19 service termination; and

160.20 (4) the facility was licensed for adult foster care before ~~March 1, 2014~~ June 30, 2016.

160.21 (g) The commissioner shall not issue a new adult foster care license under paragraph (f)
160.22 after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care
160.23 license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity
160.24 of ~~five~~ or six adults if the license holder continues to comply with the requirements in
160.25 paragraph (f).

160.26 Sec. 3. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

160.27 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
160.28 and community-based services to persons with disabilities and persons age 65 and older
160.29 pursuant to this chapter. The licensing standards in this chapter govern the provision of
160.30 basic support services and intensive support services.

160.31 (b) Basic support services provide the level of assistance, supervision, and care that is
160.32 necessary to ensure the health and welfare of the person and do not include services that

161.1 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
161.2 person. Basic support services include:

161.3 (1) in-home and out-of-home respite care services as defined in section 245A.02,
161.4 subdivision 15, and under the brain injury, community alternative care, community access
161.5 for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans,
161.6 excluding out-of-home respite care provided to children in a family child foster care home
161.7 licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care
161.8 license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7,
161.9 and 8, or successor provisions; and section 245D.061 or successor provisions, which must
161.10 be stipulated in the statement of intended use required under Minnesota Rules, part
161.11 2960.3000, subpart 4;

161.12 (2) adult companion services as defined under the brain injury, community access for
161.13 disability inclusion, community alternative care, and elderly waiver plans, excluding adult
161.14 companion services provided under the Corporation for National and Community Services
161.15 Senior Companion Program established under the Domestic Volunteer Service Act of 1973,
161.16 Public Law 98-288;

161.17 (3) personal support as defined under the developmental ~~disability~~ disabilities waiver
161.18 plan;

161.19 (4) 24-hour emergency assistance, personal emergency response as defined under the
161.20 community access for disability inclusion and developmental ~~disability~~ disabilities waiver
161.21 plans;

161.22 (5) night supervision services as defined under the brain injury, community access for
161.23 disability inclusion, community alternative care, and developmental disabilities waiver ~~plan~~
161.24 plans;

161.25 (6) homemaker services as defined under the community access for disability inclusion,
161.26 brain injury, community alternative care, developmental ~~disability~~ disabilities, and elderly
161.27 waiver plans, excluding providers licensed by the Department of Health under chapter 144A
161.28 and those providers providing cleaning services only; and

161.29 (7) individual community living support under section 256B.0915, subdivision 3j.

161.30 (c) Intensive support services provide assistance, supervision, and care that is necessary
161.31 to ensure the health and welfare of the person and services specifically directed toward the
161.32 training, habilitation, or rehabilitation of the person. Intensive support services include:

161.33 (1) intervention services, including:

162.1 (i) ~~behavioral~~ positive support services as defined under the brain injury and community
 162.2 access for disability inclusion, community alternative care, and developmental disabilities
 162.3 waiver plans;

162.4 (ii) in-home or out-of-home crisis respite services as defined under the brain injury,
 162.5 community access for disability inclusion, community alternative care, and developmental
 162.6 disability disabilities waiver ~~plan~~ plans; and

162.7 (iii) specialist services as defined under the current brain injury, community access for
 162.8 disability inclusion, community alternative care, and developmental ~~disability~~ disabilities
 162.9 waiver ~~plan~~ plans;

162.10 (2) in-home support services, including:

162.11 (i) in-home family support and supported living services as defined under the
 162.12 developmental ~~disability~~ disabilities waiver plan;

162.13 (ii) independent living services training as defined under the brain injury and community
 162.14 access for disability inclusion waiver plans;

162.15 (iii) semi-independent living services; and

162.16 (iv) individualized home supports services as defined under the brain injury, community
 162.17 alternative care, and community access for disability inclusion waiver plans;

162.18 (3) residential supports and services, including:

162.19 (i) supported living services as defined under the developmental ~~disability~~ disabilities
 162.20 waiver plan provided in a family or corporate child foster care residence, a family adult
 162.21 foster care residence, a community residential setting, or a supervised living facility;

162.22 (ii) foster care services as defined in the brain injury, community alternative care, and
 162.23 community access for disability inclusion waiver plans provided in a family or corporate
 162.24 child foster care residence, a family adult foster care residence, or a community residential
 162.25 setting; and

162.26 (iii) residential services provided to more than four persons with developmental
 162.27 disabilities in a supervised living facility, including ICFs/DD;

162.28 (4) day services, including:

162.29 (i) structured day services as defined under the brain injury waiver plan;

162.30 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
 162.31 under the developmental ~~disability~~ disabilities waiver plan; and

163.1 (iii) prevocational services as defined under the brain injury and community access for
 163.2 disability inclusion waiver plans; and

163.3 (5) employment exploration services as defined under the brain injury, community
 163.4 alternative care, community access for disability inclusion, and developmental ~~disability~~
 163.5 disabilities waiver plans;

163.6 (6) employment development services as defined under the brain injury, community
 163.7 alternative care, community access for disability inclusion, and developmental ~~disability~~
 163.8 disabilities waiver plans; and

163.9 (7) employment support services as defined under the brain injury, community alternative
 163.10 care, community access for disability inclusion, and developmental ~~disability~~ disabilities
 163.11 waiver plans.

163.12 Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

163.13 Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the
 163.14 person or the person's legal representative and case manager an opportunity to participate
 163.15 in the ongoing review and development of the service plan and the methods used to support
 163.16 the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per
 163.17 year, or within 30 days of a written request by the person, the person's legal representative,
 163.18 or the case manager, the license holder, in coordination with the person's support team or
 163.19 expanded support team, must meet with the person, the person's legal representative, and
 163.20 the case manager, and participate in service plan review meetings following stated timelines
 163.21 established in the person's coordinated service and support plan or coordinated service and
 163.22 support plan addendum ~~or within 30 days of a written request by the person, the person's~~
 163.23 ~~legal representative, or the case manager, at a minimum of once per year.~~ The purpose of
 163.24 the service plan review is to determine whether changes are needed to the service plan based
 163.25 on the assessment information, the license holder's evaluation of progress towards
 163.26 accomplishing outcomes, or other information provided by the support team or expanded
 163.27 support team.

163.28 (b) At least once per year, the license holder, in coordination with the person's support
 163.29 team or expanded support team, must meet with the person, the person's legal representative,
 163.30 and the case manager to discuss how technology might be used to meet the person's desired
 163.31 outcomes. The coordinated service and support plan addendum must include a summary of
 163.32 this discussion. The summary must include a statement regarding any decision made related
 163.33 to the use of technology and a description of any further research that must be completed
 163.34 before a decision regarding the use of technology can be made. Nothing in this paragraph

164.1 requires the coordinated service and support plan addendum to include the use of technology
 164.2 for the provision of services.

164.3 ~~(b)~~ (c) The license holder must summarize the person's status and progress toward
 164.4 achieving the identified outcomes and make recommendations and identify the rationale
 164.5 for changing, continuing, or discontinuing implementation of supports and methods identified
 164.6 in subdivision 4 in a report available at the time of the progress review meeting. The report
 164.7 must be sent at least five working days prior to the progress review meeting if requested by
 164.8 the team in the coordinated service and support plan or coordinated service and support
 164.9 plan addendum.

164.10 ~~(e)~~ (d) The license holder must send the coordinated service and support plan addendum
 164.11 to the person, the person's legal representative, and the case manager by mail within ten
 164.12 working days of the progress review meeting. Within ten working days of the mailing of
 164.13 the coordinated service and support plan addendum, the license holder must obtain dated
 164.14 signatures from the person or the person's legal representative and the case manager to
 164.15 document approval of any changes to the coordinated service and support plan addendum.

164.16 ~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and
 164.17 support plan and coordinated service and support plan addendum, the person or the person's
 164.18 legal representative or case manager has not signed and returned to the license holder the
 164.19 coordinated service and support plan or coordinated service and support plan addendum or
 164.20 has not proposed written modifications to the license holder's submission, the submission
 164.21 is deemed approved and the coordinated service and support plan addendum becomes
 164.22 effective and remains in effect until the legal representative or case manager submits a
 164.23 written request to revise the coordinated service and support plan addendum.

164.24 Sec. 5. Minnesota Statutes 2018, section 245D.09, subdivision 5, is amended to read:

164.25 Subd. 5. **Annual training.** A license holder must provide annual training to direct support
 164.26 staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff
 164.27 has a first aid certification, annual training under subdivision 4, clause (9), is not required
 164.28 as long as the certification remains current. ~~A license holder must provide a minimum of~~
 164.29 ~~24 hours of annual training to direct service staff providing intensive services and having~~
 164.30 ~~fewer than five years of documented experience and 12 hours of annual training to direct~~
 164.31 ~~service staff providing intensive services and having five or more years of documented~~
 164.32 ~~experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on~~
 164.33 ~~relevant topics received from sources other than the license holder may count toward training~~
 164.34 ~~requirements. A license holder must provide a minimum of 12 hours of annual training to~~

165.1 ~~direct service staff providing basic services and having fewer than five years of documented~~
 165.2 ~~experience and six hours of annual training to direct service staff providing basic services~~
 165.3 ~~and having five or more years of documented experience.~~

165.4 Sec. 6. Minnesota Statutes 2018, section 245D.09, subdivision 5a, is amended to read:

165.5 Subd. 5a. **Alternative sources of training.** ~~The commissioner may approve online~~
 165.6 ~~training and competency-based assessments in place of a specific number of hours of training~~
 165.7 ~~in the topics covered in subdivision 4. The commissioner must provide a list of preapproved~~
 165.8 ~~trainings that do not need approval for each individual license holder.~~

165.9 Orientation or training received by the staff person from sources other than the license
 165.10 holder in the same subjects as identified in subdivision 4 may count toward the orientation
 165.11 and annual training requirements if received in the 12-month period before the staff person's
 165.12 date of hire. The license holder must maintain documentation of the training received from
 165.13 other sources and of each staff person's competency in the required area according to the
 165.14 requirements in subdivision 3.

165.15 Sec. 7. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

165.16 Subd. 2. ~~Behavior~~ **Positive support professional qualifications.** A ~~behavior~~ positive
 165.17 support professional providing behavioral positive support services as identified in section
 165.18 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
 165.19 following areas as required under the brain injury ~~and~~ community access for disability
 165.20 inclusion, community alternative care, and developmental disabilities waiver plans or
 165.21 successor plans:

165.22 (1) ethical considerations;

165.23 (2) functional assessment;

165.24 (3) functional analysis;

165.25 (4) measurement of behavior and interpretation of data;

165.26 (5) selecting intervention outcomes and strategies;

165.27 (6) behavior reduction and elimination strategies that promote least restrictive approved
 165.28 alternatives;

165.29 (7) data collection;

165.30 (8) staff and caregiver training;

166.1 (9) support plan monitoring;

166.2 (10) co-occurring mental disorders or neurocognitive disorder;

166.3 (11) demonstrated expertise with populations being served; and

166.4 (12) must be a:

166.5 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
166.6 of Psychology competencies in the above identified areas;

166.7 (ii) clinical social worker licensed as an independent clinical social worker under chapter
166.8 148D, or a person with a master's degree in social work from an accredited college or
166.9 university, with at least 4,000 hours of post-master's supervised experience in the delivery
166.10 of clinical services in the areas identified in clauses (1) to (11);

166.11 (iii) physician licensed under chapter 147 and certified by the American Board of
166.12 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
166.13 in the areas identified in clauses (1) to (11);

166.14 (iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39
166.15 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical
166.16 services who has demonstrated competencies in the areas identified in clauses (1) to (11);

166.17 (v) person with a master's degree from an accredited college or university in one of the
166.18 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
166.19 experience in the delivery of clinical services with demonstrated competencies in the areas
166.20 identified in clauses (1) to (11); ~~or~~

166.21 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
166.22 fields with demonstrated expertise in positive support services; or

166.23 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
166.24 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
166.25 mental health nursing by a national nurse certification organization, or who has a master's
166.26 degree in nursing or one of the behavioral sciences or related fields from an accredited
166.27 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
166.28 experience in the delivery of clinical services.

166.29 Sec. 8. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

166.30 Subd. 3. ~~Behavior~~ **Positive support analyst qualifications.** (a) A ~~behavior~~ positive
166.31 support analyst providing ~~behavioral~~ positive support services as identified in section
166.32 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the

167.1 following areas as required under the brain injury ~~and~~ community access for disability
 167.2 inclusion, community alternative care, and developmental disabilities waiver plans or
 167.3 successor plans:

167.4 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
 167.5 discipline; ~~or~~

167.6 (2) meet the qualifications of a mental health practitioner as defined in section 245.462,
 167.7 subdivision 17; or

167.8 (3) be a board-certified behavior analyst or board-certified assistant behavior analyst by
 167.9 the Behavior Analyst Certification Board, Incorporated.

167.10 (b) In addition, a ~~behavior~~ positive support analyst must:

167.11 (1) have four years of supervised experience ~~working with individuals who exhibit~~
 167.12 ~~challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~
 167.13 conducting functional behavior assessments and designing, implementing, and evaluating
 167.14 effectiveness of positive practices behavior support strategies for people who exhibit
 167.15 challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

167.16 (2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~
 167.17 training prior to hire or within 90 calendar days of hire that includes:

167.18 (i) ten hours of instruction in functional assessment and functional analysis;

167.19 (ii) 20 hours of instruction in the understanding of the function of behavior;

167.20 (iii) ten hours of instruction on design of positive practices behavior support strategies;

167.21 (iv) 20 hours of instruction preparing written intervention strategies, designing data
 167.22 collection protocols, training other staff to implement positive practice strategies,
 167.23 summarizing and reporting program evaluation data, analyzing program evaluation data to
 167.24 identify design flaws in behavioral interventions or failures in implementation fidelity, and
 167.25 recommending enhancements based on evaluation data; and

167.26 (v) eight hours of instruction on principles of person-centered thinking;

167.27 (3) ~~have received 20 hours of instruction in the understanding of the function of behavior;~~

167.28 (4) ~~have received ten hours of instruction on design of positive practices behavior support~~
 167.29 ~~strategies;~~

167.30 (5) ~~have received 20 hours of instruction on the use of behavior reduction approved~~
 167.31 ~~strategies used only in combination with behavior positive practices strategies;~~

168.1 ~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training
 168.2 and prerequisite skills required to provide positive practice strategies as well as behavior
 168.3 reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive
 168.4 support; and

168.5 ~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

168.6 (c) Meeting the qualifications for a positive support professional under subdivision 2
 168.7 shall substitute for meeting the qualifications listed in paragraph (b).

168.8 Sec. 9. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

168.9 Subd. 4. **Behavior Positive support specialist qualifications.** (a) A ~~behavior~~ positive
 168.10 support specialist providing ~~behavioral~~ positive support services as identified in section
 168.11 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the
 168.12 following areas as required under the brain injury ~~and~~ community access for disability
 168.13 inclusion, community alternative care, and developmental disabilities waiver plans or
 168.14 successor plans:

168.15 (1) have an associate's degree in a social services discipline; or

168.16 (2) have two years of supervised experience working with individuals who exhibit
 168.17 challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

168.18 (b) In addition, a behavior specialist must:

168.19 (1) have received training prior to hire or within 90 calendar days of hire that includes:

168.20 (i) a minimum of four hours of training in functional assessment;

168.21 ~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of
 168.22 behavior;

168.23 ~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral
 168.24 support strategies; and

168.25 (iv) eight hours of instruction on principles of person-centered thinking;

168.26 ~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training
 168.27 and prerequisite skills required to provide positive practices strategies as well as behavior
 168.28 reduction approved intervention to the person who receives ~~behavioral~~ positive support;
 168.29 and

168.30 ~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

169.1 (c) Meeting the qualifications for a positive support professional under subdivision 2
169.2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

169.3 Sec. 10. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

169.4 Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made
169.5 pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant
169.6 to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services
169.7 for any person if the costs exceed the state share of the average medical assistance costs for
169.8 services provided by intermediate care facilities for a person with a developmental disability
169.9 for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any
169.10 person if the costs exceed \$1,500 in a state fiscal year. The commissioner may make
169.11 payments to each county in quarterly installments. The commissioner may certify an advance
169.12 of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement
169.13 basis for reported expenditures and may be adjusted for anticipated spending patterns.

169.14 Sec. 11. **[256.488] ADAPTIVE FITNESS ACCESS GRANT.**

169.15 Subdivision 1. **Definitions.** (a) "Adaptive fitness" means the practice of physical fitness
169.16 by an individual with primary physical disabilities, either as a consequence of the natural
169.17 aging process or due to a developmental disability, mental health issue, congenital condition,
169.18 trauma, injury, or disease.

169.19 (b) "Adaptive fitness center" means a center with modified equipment, equipment
169.20 arrangement and space for access, and trainers with skills in modifying exercise programs
169.21 specific to the physical and cognitive needs of individuals with disabilities.

169.22 (c) "Commissioner" means the commissioner of human services.

169.23 (d) "Disability" has the meaning given in the Americans with Disabilities Act.

169.24 Subd. 2. **Establishment.** A statewide adaptive fitness access grant program is established
169.25 under the Department of Human Services to award grants to promote access to adaptive
169.26 fitness for individuals with disabilities.

169.27 Subd. 3. **Application and review.** (a) The commissioner must develop a grant application
169.28 that must contain, at a minimum:

169.29 (1) a description of the purpose or project for which the grant will be used;

169.30 (2) a description of the specific problem the grant intends to address;

170.1 (3) a description of achievable objectives, a work plan, and a timeline for implementation
170.2 and completion of processes or projects enabled by the grant;

170.3 (4) a description of the existing frameworks and experience providing adaptive fitness;
170.4 and

170.5 (5) a proposed process for documenting and evaluating results of the grant.

170.6 (b) An applicant must apply using the grant application developed by the commissioner.

170.7 (c) The commissioner shall review each application. The commissioner shall establish
170.8 criteria to evaluate applications, including but not limited to:

170.9 (1) the application is complete;

170.10 (2) the eligibility of the applicant;

170.11 (3) the thoroughness and clarity in identifying the specific problem the grant intends to
170.12 address;

170.13 (4) a description of the population demographics and service area of the proposed project;

170.14 (5) documentation the grant applicant has received cash or in-kind contributions of value
170.15 equal to the requested grant amount; and

170.16 (6) the proposed project's longevity and demonstrated financial sustainability after the
170.17 initial grant period.

170.18 (d) In evaluating applications, the commissioner may request additional information
170.19 regarding a proposed project, including information on project cost. An applicant's failure
170.20 to timely provide the information requested disqualifies an applicant.

170.21 Subd. 4. **Awards.** (a) The commissioner shall award grants to eligible applicants to
170.22 provide adaptive fitness for individuals with disabilities.

170.23 (b) The commissioner shall award grants to qualifying nonprofit organizations that
170.24 provide adaptive fitness in adaptive fitness centers. Grants must be used to assist one or
170.25 more qualified nonprofit organizations to provide adaptive fitness, including: (1) stay fit;
170.26 (2) activity-based locomotor exercise; (3) equipment necessary for adaptive fitness programs;
170.27 (4) operating expenses related to staffing of adaptive fitness programs; and (5) other adaptive
170.28 fitness programs as deemed appropriate by the commissioner.

170.29 (c) An applicant may apply for and the commissioner may award grants for two-year
170.30 periods, and the commissioner shall determine the number of grants awarded. The
170.31 commissioner may reallocate underspending among grantees within the same grant period.

171.1 Subd. 5. **Report.** Beginning December 1, 2020, and every two years thereafter, the
171.2 commissioner of human services shall submit a report to the chairs and ranking minority
171.3 members of the legislative committees with jurisdiction over health and human services.
171.4 The report shall, at a minimum, include the amount of funding awarded for each project, a
171.5 description of the programs and services funded, plans for the long-term sustainability of
171.6 the projects, and data on outcomes for the programs and services funded. Grantees must
171.7 provide information and data requested by the commissioner to support the development
171.8 of this report.

171.9 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 19a, is amended to
171.10 read:

171.11 Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care
171.12 assistance services in a recipient's home. Effective January 1, ~~2010~~ 2020, to qualify for
171.13 personal care assistance services, a recipient must require assistance and be determined
171.14 dependent in one critical activity of daily living as defined in section 256B.0659, subdivision
171.15 1, paragraph ~~(b)~~ (e), or in a Level I behavior as defined in section 256B.0659, subdivision
171.16 1, paragraph (c), or have a behavior that shows increased vulnerability due to cognitive
171.17 deficits or socially inappropriate behavior that requires assistance at least four times per
171.18 week. Recipients or responsible parties must be able to identify the recipient's needs, direct
171.19 and evaluate task accomplishment, and provide for health and safety. Approved hours may
171.20 be used outside the home when normal life activities take them outside the home. To use
171.21 personal care assistance services at school, the recipient or responsible party must provide
171.22 written authorization in the care plan identifying the chosen provider and the daily amount
171.23 of services to be used at school. Total hours for services, whether actually performed inside
171.24 or outside the recipient's home, cannot exceed that which is otherwise allowed for personal
171.25 care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654.
171.26 Medical assistance does not cover personal care assistance services for residents of a hospital,
171.27 nursing facility, intermediate care facility, health care facility licensed by the commissioner
171.28 of health, or unless a resident who is otherwise eligible is on leave from the facility and the
171.29 facility either pays for the personal care assistance services or forgoes the facility per diem
171.30 for the leave days that personal care assistance services are used. All personal care assistance
171.31 services must be provided according to sections 256B.0651 to 256B.0654. Personal care
171.32 assistance services may not be reimbursed if the personal care assistant is the spouse or paid
171.33 guardian of the recipient or the parent of a recipient under age 18, or the responsible party
171.34 or the family foster care provider of a recipient who cannot direct the recipient's own care
171.35 unless, in the case of a foster care provider, a county or state case manager visits the recipient

172.1 as needed, but not less than every six months, to monitor the health and safety of the recipient
172.2 and to ensure the goals of the care plan are met. Notwithstanding the provisions of section
172.3 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party
172.4 and not the personal care provider organization, may be reimbursed to provide personal
172.5 care assistance services to the recipient if the guardian or conservator meets all criteria for
172.6 a personal care assistant according to section 256B.0659, and shall not be considered to
172.7 have a service provider interest for purposes of participation on the screening team under
172.8 section 256B.092, subdivision 7.

172.9 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
172.10 whichever is later. The commissioner shall implement the modified eligibility criteria as
172.11 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
172.12 approval is obtained.

172.13 Sec. 13. Minnesota Statutes 2018, section 256B.0652, subdivision 6, is amended to read:

172.14 Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All
172.15 personal care assistance services, supervision by a qualified professional, and additional
172.16 services beyond the limits established in subdivision 11, must be authorized by the
172.17 commissioner or the commissioner's designee before services begin except for the
172.18 assessments established in subdivision 11 and section 256B.0911. The authorization for
172.19 personal care assistance and qualified professional services under section 256B.0659 must
172.20 be completed within 30 days after receiving a complete request.

172.21 (b) The amount of personal care assistance services authorized must be based on the
172.22 recipient's home care rating. The home care rating shall be determined by the commissioner
172.23 or the commissioner's designee based on information submitted to the commissioner
172.24 identifying the following for recipients with dependencies in two or more activities of daily
172.25 living:

172.26 (1) total number of dependencies of activities of daily living as defined in section
172.27 256B.0659;

172.28 (2) presence of complex health-related needs as defined in section 256B.0659; and

172.29 (3) presence of Level I behavior as defined in section 256B.0659.

172.30 (c) For purposes meeting the criteria in paragraph (b), the methodology to determine
172.31 total time for personal care assistance services for each home care rating is based on the
172.32 median paid units per day for each home care rating from fiscal year 2007 data for the

173.1 personal care assistance program. Each home care rating has a base level of hours assigned.

173.2 Additional time is added through the assessment and identification of the following:

173.3 (1) 30 additional minutes per day for a dependency in each critical activity of daily living
173.4 as defined in section 256B.0659;

173.5 (2) 30 additional minutes per day for each complex health-related function as defined
173.6 in section 256B.0659; and

173.7 (3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659,
173.8 subdivision 4, paragraph (d).

173.9 (d) Effective July 1, 2011, the home care rating for recipients who have a dependency
173.10 in one activity of daily living or Level I behavior shall equal no more than two units per
173.11 day. Effective January 1, 2020, the home care rating for recipients who have a dependency
173.12 in one critical activity of daily living or one Level I behavior or that require assistance with
173.13 a behavior that shows increased vulnerability due to cognitive deficits or socially
173.14 inappropriate behavior at least four times per week shall equal no more than two units per
173.15 day. Recipients with this home care rating are not subject to the methodology in paragraph
173.16 (c) and are not eligible for more than two units per day.

173.17 (e) A limit of 96 units of qualified professional supervision may be authorized for each
173.18 recipient receiving personal care assistance services. A request to the commissioner to
173.19 exceed this total in a calendar year must be requested by the personal care provider agency
173.20 on a form approved by the commissioner.

173.21 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
173.22 whichever is later. The commissioner shall implement the modified eligibility criteria as
173.23 annual assessments occur. The commissioner shall notify the revisor of statutes when federal
173.24 approval is obtained.

173.25 Sec. 14. Minnesota Statutes 2018, section 256B.0658, is amended to read:

173.26 **256B.0658 HOUSING ACCESS GRANTS.**

173.27 The commissioner of human services shall award through a competitive process contracts
173.28 for grants to public and private agencies to support and assist individuals ~~eligible for publicly~~
173.29 ~~funded home and community-based services, including state plan home care~~ with a disability
173.30 as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may
173.31 be awarded to agencies that may include, but are not limited to, the following supports:
173.32 assessment to ensure suitability of housing, accompanying an individual to look at housing,
173.33 filling out applications and rental agreements, meeting with landlords, helping with Section

174.1 8 or other program applications, helping to develop a budget, obtaining furniture and
174.2 household goods, if necessary, and assisting with any problems that may arise with housing.

174.3 Sec. 15. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

174.4 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a
174.5 recipient's need for personal care assistance services conducted in person. Assessments for
174.6 personal care assistance services shall be conducted by the county public health nurse or a
174.7 certified public health nurse under contract with the county except when a long-term care
174.8 consultation assessment is being conducted for the purposes of determining a person's
174.9 eligibility for home and community-based waiver services including personal care assistance
174.10 services according to section 256B.0911. During the transition to MnCHOICES, a certified
174.11 assessor may complete the assessment defined in this subdivision. An in-person assessment
174.12 must include: documentation of health status, determination of need, evaluation of service
174.13 effectiveness, identification of appropriate services, service plan development or modification,
174.14 coordination of services, referrals and follow-up to appropriate payers and community
174.15 resources, completion of required reports, recommendation of service authorization, and
174.16 consumer education. Once the need for personal care assistance services is determined under
174.17 this section, the county public health nurse or certified public health nurse under contract
174.18 with the county is responsible for communicating this recommendation to the commissioner
174.19 and the recipient. An in-person assessment must occur at least annually or when there is a
174.20 significant change in the recipient's condition or when there is a change in the need for
174.21 personal care assistance services. A service update may substitute for the annual face-to-face
174.22 assessment when there is not a significant change in recipient condition or a change in the
174.23 need for personal care assistance service. A service update may be completed by telephone,
174.24 used when there is no need for an increase in personal care assistance services, and used
174.25 for two consecutive assessments if followed by a face-to-face assessment. A service update
174.26 must be completed on a form approved by the commissioner. A service update or review
174.27 for temporary increase includes a review of initial baseline data, evaluation of service
174.28 effectiveness, redetermination of service need, modification of service plan and appropriate
174.29 referrals, update of initial forms, obtaining service authorization, and on going consumer
174.30 education. Assessments or reassessments must be completed on forms provided by the
174.31 commissioner within 30 days of a request for home care services by a recipient or responsible
174.32 party.

174.33 (b) This subdivision expires when notification is given by the commissioner as described
174.34 in section 256B.0911, subdivision 3a.

175.1 Sec. 16. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

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

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

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

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

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

175.10 (3) enroll with the department as a personal care assistant after clearing a background
175.11 study. Except as provided in subdivision 11a, before a personal care assistant provides
175.12 services, the personal care assistance provider agency must initiate a background study on
175.13 the personal care assistant under chapter 245C, and the personal care assistance provider
175.14 agency must have received a notice from the commissioner that the personal care assistant
175.15 is:

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

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

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

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

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

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

175.27 (8) effective January 1, 2010, complete standardized training as determined by the
175.28 commissioner before completing enrollment. The training must be available in languages
175.29 other than English and to those who need accommodations due to disabilities. Personal care
175.30 assistant training must include successful completion of the following training components:
175.31 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
175.32 roles and responsibilities of personal care assistants including information about assistance

176.1 with lifting and transfers for recipients, emergency preparedness, orientation to positive
176.2 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
176.3 training components, the personal care assistant must demonstrate the competency to provide
176.4 assistance to recipients;

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

176.6 (10) be limited to providing and being paid for up to 275 hours per month of personal
176.7 care assistance services regardless of the number of recipients being served or the number
176.8 of personal care assistance provider agencies enrolled with. The number of hours worked
176.9 per day shall not be disallowed by the department unless in violation of the law.

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

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

176.16 (d) Personal care assistance services qualify for the enhanced rate described in subdivision
176.17 17a if the personal care assistant providing the services:

176.18 (1) provides services, according to the care plan in subdivision 7, to a recipient who
176.19 qualifies for ten or more hours per day of personal care assistance services; and

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

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

176.25 Sec. 17. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision
176.26 to read:

176.27 Subd. 17a. **Enhanced rate.** An enhanced rate of 110 percent of the rate paid for personal
176.28 care assistance services shall be paid for services provided to persons who qualify for ten
176.29 or more hours of personal care assistance service per day when provided by a personal care
176.30 assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate
176.31 for personal care assistance services includes, and is not in addition to, any rate adjustments
176.32 implemented by the commissioner to comply with the terms of a collective bargaining

177.1 agreement between the state of Minnesota and an exclusive representative of individual
177.2 providers under section 179A.54 for increased financial incentives for providing services
177.3 to people with complex needs.

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

177.5 Sec. 18. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

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

177.21 (5) proof of liability insurance;

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

177.25 (7) a copy of the personal care assistance provider agency's written policies and
177.26 procedures including: hiring of employees; training requirements; service delivery; and
177.27 employee and consumer safety including process for notification and resolution of consumer
177.28 grievances, identification and prevention of communicable diseases, and employee
177.29 misconduct;

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

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

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

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

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

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

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

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

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

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

178.30 (b) Personal care assistance provider agencies shall provide the information specified
178.31 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
178.32 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect

179.1 the information specified in paragraph (a) from all personal care assistance providers
179.2 beginning July 1, 2009.

179.3 (c) All personal care assistance provider agencies shall require all employees in
179.4 management and supervisory positions and owners of the agency who are active in the
179.5 day-to-day management and operations of the agency to complete mandatory training as
179.6 determined by the commissioner before enrollment of the agency as a provider. Employees
179.7 in management and supervisory positions and owners who are active in the day-to-day
179.8 operations of an agency who have completed the required training as an employee with a
179.9 personal care assistance provider agency do not need to repeat the required training if they
179.10 are hired by another agency, if they have completed the training within the past three years.
179.11 By September 1, 2010, the required training must be available with meaningful access
179.12 according to title VI of the Civil Rights Act and federal regulations adopted under that law
179.13 or any guidance from the United States Health and Human Services Department. The
179.14 required training must be available online or by electronic remote connection. The required
179.15 training must provide for competency testing. Personal care assistance provider agency
179.16 billing staff shall complete training about personal care assistance program financial
179.17 management. This training is effective July 1, 2009. Any personal care assistance provider
179.18 agency enrolled before that date shall, if it has not already, complete the provider training
179.19 within 18 months of July 1, 2009. Any new owners or employees in management and
179.20 supervisory positions involved in the day-to-day operations are required to complete
179.21 mandatory training as a requisite of working for the agency. Personal care assistance provider
179.22 agencies certified for participation in Medicare as home health agencies are exempt from
179.23 the training required in this subdivision. When available, Medicare-certified home health
179.24 agency owners, supervisors, or managers must successfully complete the competency test.

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

179.26 Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

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

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

- 180.1 (4) comply with background study requirements;
- 180.2 (5) verify and keep records of hours worked by the personal care assistant and qualified
180.3 professional;
- 180.4 (6) not engage in any agency-initiated direct contact or marketing in person, by phone,
180.5 or other electronic means to potential recipients, guardians, or family members;
- 180.6 (7) pay the personal care assistant and qualified professional based on actual hours of
180.7 services provided;
- 180.8 (8) withhold and pay all applicable federal and state taxes;
- 180.9 (9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent
180.10 of the revenue generated by the medical assistance rate for personal care assistance services
180.11 for employee personal care assistant wages and benefits. The revenue generated by the
180.12 qualified professional and the reasonable costs associated with the qualified professional
180.13 shall not be used in making this calculation;
- 180.14 (10) make the arrangements and pay unemployment insurance, taxes, workers'
180.15 compensation, liability insurance, and other benefits, if any;
- 180.16 (11) enter into a written agreement under subdivision 20 before services are provided;
- 180.17 (12) report suspected neglect and abuse to the common entry point according to section
180.18 256B.0651;
- 180.19 (13) provide the recipient with a copy of the home care bill of rights at start of service;
180.20 ~~and~~
- 180.21 (14) request reassessments at least 60 days prior to the end of the current authorization
180.22 for personal care assistance services, on forms provided by the commissioner; and
- 180.23 (15) document that the agency uses the additional revenue due to the enhanced rate under
180.24 subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements
180.25 under subdivision 11, paragraph (d).

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

180.27 Sec. 20. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

180.28 Subd. 28. **Personal care assistance provider agency; required documentation.** (a)

180.29 Required documentation must be completed and kept in the personal care assistance provider
180.30 agency file or the recipient's home residence. The required documentation consists of:

180.31 (1) employee files, including:

- 181.1 (i) applications for employment;
- 181.2 (ii) background study requests and results;
- 181.3 (iii) orientation records about the agency policies;
- 181.4 (iv) trainings completed with demonstration of competence, including verification of
- 181.5 the completion of training required under subdivision 11, paragraph (d), for any services
- 181.6 billed at the enhanced rate under subdivision 17a;
- 181.7 (v) supervisory visits;
- 181.8 (vi) evaluations of employment; and
- 181.9 (vii) signature on fraud statement;
- 181.10 (2) recipient files, including:
 - 181.11 (i) demographics;
 - 181.12 (ii) emergency contact information and emergency backup plan;
 - 181.13 (iii) personal care assistance service plan;
 - 181.14 (iv) personal care assistance care plan;
 - 181.15 (v) month-to-month service use plan;
 - 181.16 (vi) all communication records;
 - 181.17 (vii) start of service information, including the written agreement with recipient; and
 - 181.18 (viii) date the home care bill of rights was given to the recipient;
- 181.19 (3) agency policy manual, including:
 - 181.20 (i) policies for employment and termination;
 - 181.21 (ii) grievance policies with resolution of consumer grievances;
 - 181.22 (iii) staff and consumer safety;
 - 181.23 (iv) staff misconduct; and
 - 181.24 (v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and
 - 181.25 resolution of consumer grievances;
- 181.26 (4) time sheets for each personal care assistant along with completed activity sheets for
- 181.27 each recipient served; and

182.1 (5) agency marketing and advertising materials and documentation of marketing activities
182.2 and costs.

182.3 (b) The commissioner may assess a fine of up to \$500 on provider agencies that do not
182.4 consistently comply with the requirements of this subdivision.

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

182.6 Sec. 21. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

182.19 (6) determination of home and community-based waiver and other service eligibility as
182.20 required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level
182.21 of care determination for individuals who need an institutional level of care as determined
182.22 under subdivision 4e, based on assessment and community support plan development,
182.23 appropriate referrals to obtain necessary diagnostic information, and including an eligibility
182.24 determination for consumer-directed community supports;

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

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

182.29 (9) providing information about competitive employment, with or without supports, for
182.30 school-age youth and working-age adults and referrals to the Disability Linkage Line and
182.31 Disability Benefits 101 to ensure that an informed choice about competitive employment

183.1 can be made. For the purposes of this subdivision, "competitive employment" means work
 183.2 in the competitive labor market that is performed on a full-time or part-time basis in an
 183.3 integrated setting, and for which an individual is compensated at or above the minimum
 183.4 wage, but not less than the customary wage and level of benefits paid by the employer for
 183.5 the same or similar work performed by individuals without disabilities.

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

183.8 (1) service eligibility determination for state plan ~~home care~~ services identified in:

183.9 (i) section 256B.0625, subdivisions ~~7~~, 19a, and 19c;

183.10 (ii) consumer support grants under section 256.476; or

183.11 (iii) section 256B.85;

183.12 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
 183.13 ~~determination of eligibility for gaining access to~~ case management services available under
 183.14 sections 256B.0621, subdivision 2, ~~paragraph clause~~ (4), and 256B.0924, and Minnesota
 183.15 Rules, part 9525.0016;

183.16 (3) ~~determination of institutional level of care, home and community-based service~~
 183.17 ~~waiver, and other service of eligibility as required under section 256B.092, determination~~
 183.18 ~~of eligibility for family support grants under section 252.32, for~~ semi-independent living
 183.19 services under section 252.275, ~~and day training and habilitation services under section~~
 183.20 ~~256B.092~~; and

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

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

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

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

184.1 (f) "Person-centered planning" is a process that includes the active participation of a
184.2 person in the planning of the person's services, including in making meaningful and informed
184.3 choices about the person's own goals, talents, and objectives, as well as making meaningful
184.4 and informed choices about the services the person receives. For the purposes of this section,
184.5 "informed choice" means a voluntary choice of services by a person from all available
184.6 service options based on accurate and complete information concerning all available service
184.7 options and concerning the person's own preferences, abilities, goals, and objectives. In
184.8 order for a person to make an informed choice, all available options must be developed and
184.9 presented to the person to empower the person to make decisions.

184.10 Sec. 22. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

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

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

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

184.28 (d) The assessment must be conducted in a face-to-face conversational interview with
184.29 the person being assessed ~~and~~. The person's legal representative must provide input during
184.30 the assessment process and may do so remotely if requested. At the request of the person,
184.31 other individuals may participate in the assessment to provide information on the needs,
184.32 strengths, and preferences of the person necessary to develop a community support plan
184.33 that ensures the person's health and safety. Except for legal representatives or family members
184.34 invited by the person, persons participating in the assessment may not be a provider of

185.1 service or have any financial interest in the provision of services. For persons who are to
185.2 be assessed for elderly waiver customized living or adult day services under section
185.3 256B.0915, with the permission of the person being assessed or the person's designated or
185.4 legal representative, the client's current or proposed provider of services may submit a copy
185.5 of the provider's nursing assessment or written report outlining its recommendations regarding
185.6 the client's care needs. The person conducting the assessment must notify the provider of
185.7 the date by which this information is to be submitted. This information shall be provided
185.8 to the person conducting the assessment prior to the assessment. For a person who is to be
185.9 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
185.10 the person being assessed or the person's designated legal representative, the person's current
185.11 provider of services may submit a written report outlining recommendations regarding the
185.12 person's care needs ~~prepared by a direct service employee with at least 20 hours of service~~
185.13 ~~to that client. The person conducting the assessment or reassessment must notify the provider~~
185.14 ~~of the date by which this information is to be submitted. This information shall be provided~~
185.15 ~~to the person conducting the assessment and the person or the person's legal representative,~~
185.16 ~~and must be considered prior to the finalization of the assessment or reassessment~~ the person
185.17 completed in consultation with someone who is known to the person and has interaction
185.18 with the person on a regular basis. The provider must submit the report at least 60 days
185.19 before the end of the person's current service agreement. The certified assessor must consider
185.20 the content of the submitted report prior to finalizing the person's assessment or reassessment.

185.21 (e) The certified assessor and the individual responsible for developing the coordinated
185.22 service and support plan must complete the community support plan and the coordinated
185.23 service and support plan no more than 60 calendar days from the assessment visit. The
185.24 person or the person's legal representative must be provided with a written community
185.25 support plan within ~~40 calendar days of the assessment visit~~ the timelines established by
185.26 the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota
185.27 health care programs.

185.28 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
185.29 provider who submitted information under paragraph (d) shall receive the final written
185.30 community support plan when available and the Residential Services Workbook.

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

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

186.1 (2) the individual's options and choices to meet identified needs, including all available
186.2 options for case management services and providers, including service provided in a
186.3 non-disability-specific setting;

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

186.6 (4) referral information; and

186.7 (5) informal caregiver supports, if applicable.

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

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

186.16 (i) The person has the right to make the final decision between institutional placement
186.17 and community placement after the recommendations have been provided, except as provided
186.18 in section 256.975, subdivision 7a, paragraph (d).

186.19 (j) The lead agency must give the person receiving assessment or support planning, or
186.20 the person's legal representative, materials, and forms supplied by the commissioner
186.21 containing the following information:

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

186.24 (2) documentation that the most cost-effective alternatives available were offered to the
186.25 individual. For purposes of this clause, "cost-effective" means community services and
186.26 living arrangements that cost the same as or less than institutional care. For an individual
186.27 found to meet eligibility criteria for home and community-based service programs under
186.28 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
186.29 approved waiver plan for each program;

186.30 (3) the need for and purpose of preadmission screening conducted by long-term care
186.31 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
186.32 nursing facility placement. If the individual selects nursing facility placement, the lead
186.33 agency shall forward information needed to complete the level of care determinations and

187.1 screening for developmental disability and mental illness collected during the assessment
187.2 to the long-term care options counselor using forms provided by the commissioner;

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

187.7 (5) information about Minnesota health care programs;

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

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

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

187.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
187.16 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
187.17 (8), and (b), and incorporating the decision regarding the need for institutional level of care
187.18 or the lead agency's final decisions regarding public programs eligibility according to section
187.19 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
187.20 to the person and must visually point out where in the document the right to appeal is stated.

187.21 (k) Face-to-face assessment completed as part of eligibility determination for the
187.22 alternative care, elderly waiver, developmental disabilities, community access for disability
187.23 inclusion, community alternative care, and brain injury waiver programs under sections
187.24 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for
187.25 no more than 60 calendar days after the date of assessment.

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

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

188.5 (n) At the time of reassessment, the certified assessor shall assess each person receiving
 188.6 waiver services currently residing in a community residential setting, or licensed adult foster
 188.7 care home that is not the primary residence of the license holder, or in which the license
 188.8 holder is not the primary caregiver, to determine if that person would prefer to be served in
 188.9 a community-living setting as defined in section 256B.49, subdivision 23. The certified
 188.10 assessor shall offer the person, through a person-centered planning process, the option to
 188.11 receive alternative housing and service options.

188.12 Sec. 23. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

188.13 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)

188.14 Prior to a face-to-face reassessment, the certified assessor must review the person's most
 188.15 recent assessment. Reassessments must be tailored using the professional judgment of the
 188.16 assessor to the person's known needs, strengths, preferences, and circumstances.

188.17 Reassessments provide information to support the person's informed choice and opportunities
 188.18 to express choice regarding activities that contribute to quality of life, as well as information
 188.19 and opportunity to identify goals related to desired employment, community activities, and
 188.20 preferred living environment. Reassessments ~~allow for~~ require a review of the most recent
 188.21 assessment, review of the current coordinated service and support plan's effectiveness,
 188.22 monitoring of services, and the development of an updated person-centered community
 188.23 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
 188.24 and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments~~
 188.25 reassessments must be conducted annually or as required by federal and state laws and rules.
 188.26 For reassessments, the certified assessor and the individual responsible for developing the
 188.27 coordinated service and support plan must ensure the continuity of care for the person
 188.28 receiving services and complete the updated community support plan and the updated
 188.29 coordinated service and support plan no more than 60 days from the reassessment visit.

188.30 (b) The commissioner shall develop mechanisms for providers and case managers to
 188.31 share information with the assessor to facilitate a reassessment and support planning process
 188.32 tailored to the person's current needs and preferences.

189.1 Sec. 24. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision
189.2 to read:

189.3 Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by
189.4 federal law, the county agency is not required to conduct or arrange for an annual needs
189.5 reassessment by a certified assessor. The case manager who works on behalf of the person
189.6 to identify the person's needs and to minimize the impact of the disability on the person's
189.7 life must instead develop a person-centered service plan based on the person's assessed
189.8 needs and preferences. The person-centered service plan must be reviewed annually for
189.9 persons with developmental disabilities who are receiving only case management services
189.10 under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an
189.11 assessment under this section.

189.12 Sec. 25. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

189.13 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
189.14 including timelines for when assessments need to be completed, required to provide the
189.15 services in this section and shall implement integrated solutions to automate the business
189.16 processes to the extent necessary for community support plan approval, reimbursement,
189.17 program planning, evaluation, and policy development.

189.18 (b) The commissioner of human services shall work with lead agencies responsible for
189.19 conducting long-term consultation services to modify the MnCHOICES application and
189.20 assessment policies to create efficiencies while ensuring federal compliance with medical
189.21 assistance and long-term services and supports eligibility criteria.

189.22 (c) The commissioner shall work with lead agencies responsible for conducting long-term
189.23 consultation services to develop a set of measurable benchmarks sufficient to demonstrate
189.24 quarterly improvement in the average time per assessment and other mutually agreed upon
189.25 measures of increasing efficiency. The commissioner shall collect data on these benchmarks
189.26 and provide to the lead agencies and the chairs and ranking minority members of the
189.27 legislative committees with jurisdiction over human services an annual trend analysis of
189.28 the data in order to demonstrate the commissioner's compliance with the requirements of
189.29 this subdivision.

189.30 Sec. 26. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

189.31 Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly
189.32 waiver client shall be provided a copy of a written coordinated service and support plan
189.33 ~~which~~ that:

190.1 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
 190.2 ~~manager receives the assessment information and written community support plan as~~
 190.3 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
 190.4 established by the commissioner. The timeline for completing the community support plan
 190.5 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
 190.6 not exceed 60 calendar days from the assessment visit;

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

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

190.11 (4) identifies the person's preferences for services as stated by the person or the person's
 190.12 legal guardian or conservator;

190.13 (5) reflects the person's informed choice between institutional and community-based
 190.14 services, as well as choice of services, supports, and providers, including available case
 190.15 manager providers;

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

190.17 (7) identifies specific services and the amount, frequency, duration, and cost of the
 190.18 services to be provided to the person based on assessed needs, preferences, and available
 190.19 resources;

190.20 (8) includes information about the right to appeal decisions under section 256.045; and

190.21 (9) includes the authorized annual and estimated monthly amounts for the services.

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

190.27 Sec. 27. Minnesota Statutes 2018, section 256B.0915, subdivision 10, is amended to read:

190.28 Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner
 190.29 shall adjust the elderly waiver capitation payment rates for managed care organizations paid
 190.30 under section 256B.69, subdivisions 6b and 23, to reflect the maximum service rate limits
 190.31 for customized living services and 24-hour customized living services under subdivisions
 190.32 3e and 3h, and the rate adjustment under subdivision 18. Medical assistance rates paid to

191.1 customized living providers by managed care organizations under this section shall not
191.2 exceed the maximum service rate limits and component rates as determined by the
191.3 commissioner under subdivisions 3e and 3h, plus any rate adjustment under subdivision
191.4 18.

191.5 Sec. 28. Minnesota Statutes 2018, section 256B.0915, is amended by adding a subdivision
191.6 to read:

191.7 **Subd. 18. Disproportionate share establishment customized living rate**
191.8 **adjustment.** (a) For purposes of this section, "designated disproportionate share
191.9 establishment" means a housing with services establishment registered under chapter 144D
191.10 that meets the requirements of paragraph (d).

191.11 (b) A housing with services establishment registered under chapter 144D may apply
191.12 annually between June 1 and June 15 to the commissioner to be designated as a
191.13 disproportionate share establishment. The applying housing with services establishment
191.14 must apply to the commissioner in the manner determined by the commissioner. The applying
191.15 housing with services establishment must document as a percentage the census of elderly
191.16 waiver participants residing in the establishment on May 31 of the year of application.

191.17 (c) Only a housing with services establishment registered under chapter 144D with a
191.18 census of at least 50 percent elderly waiver participants on May 31 of the application year
191.19 is eligible under this section for designation as a disproportionate share establishment.

191.20 (d) By June 30, the commissioner shall designate as a disproportionate share establishment
191.21 any housing with services establishment that complies with the requirements of paragraph
191.22 (b) and meets the eligibility criteria described in paragraph (c).

191.23 (e) A designated disproportionate share establishment's customized living rate adjustment
191.24 is the sum of 0.83 plus the product of 0.36 multiplied by the percentage of elderly waiver
191.25 participants residing in the establishment as reported on the establishment's most recent
191.26 application for designation as a disproportionate share establishment. No establishment may
191.27 receive a customized living rate adjustment greater than 1.10.

191.28 (f) The commissioner shall multiply the customized living rate and 24-hour customized
191.29 living rate for a designated disproportionate share establishment by the amount determined
191.30 under paragraph (e).

191.31 (g) The value of the rate adjustment under paragraph (e) shall not be included in an
191.32 individual elderly waiver client's monthly case mix budget cap.

192.1 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
192.2 whichever is later, and applies to rates paid on or after January 1, 2021. The commissioner
192.3 of human services shall inform the revisor of statutes when federal approval is obtained.

192.4 Sec. 29. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

192.5 Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and
192.6 community-based waived services shall be provided a copy of the written coordinated
192.7 service and support plan ~~which~~ that:

192.8 (1) is developed with and signed by the recipient within ~~ten working days after the case~~
192.9 ~~manager receives the assessment information and written community support plan as~~
192.10 ~~described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines
192.11 established by the commissioner. The timeline for completing the community support plan
192.12 under section 256B.0911, subdivision 3a, and the coordinated service and support plan must
192.13 not exceed 60 calendar days from the assessment visit;

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

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

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

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

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

192.26 (7) identifies specific services and the amount and frequency of the services to be provided
192.27 to the person based on assessed needs, preferences, and available resources. The coordinated
192.28 service and support plan shall also specify other services the person needs that are not
192.29 available;

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

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

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

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

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

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

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

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

193.17 Sec. 30. Minnesota Statutes 2018, section 256B.092, is amended by adding a subdivision
 193.18 to read:

193.19 Subd. 12a. **Developmental disabilities waiver growth limit.** The commissioner shall
 193.20 limit the total number of people receiving developmental disabilities waiver services to the
 193.21 number of people receiving developmental disabilities waiver services on June 30, 2019.
 193.22 The commissioner shall only add new recipients when an existing recipient permanently
 193.23 leaves the program. The commissioner shall reserve capacity, within enrollment limits, to
 193.24 re-enroll persons who temporarily discontinue and then resume waiver services within 90
 193.25 days of the date that services were discontinued. When adding a new recipient, the
 193.26 commissioner shall target persons who meet the priorities for accessing waiver services
 193.27 identified in subdivision 12. The allocation limits include conversions from intermediate
 193.28 care facilities for persons with developmental disabilities unless capacity at the facility is
 193.29 permanently converted to home and community-based services through the developmental
 193.30 disabilities waiver.

194.1 Sec. 31. Minnesota Statutes 2018, section 256B.0921, is amended to read:

194.2 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE**
 194.3 **INNOVATION POOL.**

194.4 The commissioner of human services shall develop an initiative to provide incentives
 194.5 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
 194.6 competitive employment for youth under age 25 upon their graduation from school; (3)
 194.7 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
 194.8 The commissioner shall seek requests for proposals and shall contract with one or more
 194.9 entities to provide incentive payments for meeting identified outcomes.

194.10 Sec. 32. Minnesota Statutes 2018, section 256B.49, is amended by adding a subdivision
 194.11 to read:

194.12 Subd. 11b. **Community access for disability inclusion waiver growth limit.** The
 194.13 commissioner shall limit the total number of people receiving community access for disability
 194.14 inclusion waiver services to the number of people receiving community access for disability
 194.15 inclusion waiver services on June 30, 2019. The commissioner shall only add new recipients
 194.16 when an existing recipient permanently leaves the program. The commissioner shall reserve
 194.17 capacity, within enrollment limits, to re-enroll persons who temporarily discontinue and
 194.18 then resume waiver services within 90 days of the date that services were discontinued.
 194.19 When adding a new recipient, the commissioner shall target individuals who meet the
 194.20 priorities for accessing waiver services identified in subdivision 11a. The allocation limits
 194.21 includes conversions and diversions from nursing facilities.

194.22 Sec. 33. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

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

194.26 (1) finalizing the written coordinated service and support plan within ~~ten working days~~
 194.27 after the case manager receives the plan from the certified assessor the timelines established
 194.28 by the commissioner. The timeline for completing the community support plan under section
 194.29 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed
 194.30 60 calendar days from the assessment visit;

194.31 (2) informing the recipient or the recipient's legal guardian or conservator of service
 194.32 options;

195.1 (3) assisting the recipient in the identification of potential service providers and available
195.2 options for case management service and providers, including services provided in a
195.3 non-disability-specific setting;

195.4 (4) assisting the recipient to access services and assisting with appeals under section
195.5 256.045; and

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

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

195.11 (1) finalizing the coordinated service and support plan;

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

195.14 (3) adjustments to the coordinated service and support plan.

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

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

195.29 (1) phasing out the use of prohibited procedures;

195.30 (2) acquisition of skills needed to eliminate the prohibited procedures within the plan's
195.31 timeline; and

195.32 (3) accomplishment of identified outcomes.

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

196.4 Sec. 34. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

196.5 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
196.6 conducted by certified assessors according to section 256B.0911, subdivision 2b. The
196.7 certified assessor, with the permission of the recipient or the recipient's designated legal
196.8 representative, may invite other individuals to attend the assessment. With the permission
196.9 of the recipient or the recipient's designated legal representative, the recipient's current
196.10 provider of services may submit a written report outlining their recommendations regarding
196.11 the recipient's care needs prepared by a direct service employee ~~with at least 20 hours of~~
196.12 ~~service to that client. The certified assessor must notify the provider of the date by which~~
196.13 ~~this information is to be submitted. This information shall be provided to the certified~~
196.14 ~~assessor and the person or the person's legal representative and must be considered prior to~~
196.15 ~~the finalization of the assessment or reassessment~~ who is familiar with the person. The
196.16 provider must submit the report at least 60 days before the end of the person's current service
196.17 agreement. The certified assessor must consider the content of the submitted report prior
196.18 to finalizing the person's assessment or reassessment.

196.19 (b) There must be a determination that the client requires a hospital level of care or a
196.20 nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and
196.21 subsequent assessments to initiate and maintain participation in the waiver program.

196.22 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
196.23 appropriate to determine nursing facility level of care for purposes of medical assistance
196.24 payment for nursing facility services, only face-to-face assessments conducted according
196.25 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
196.26 determination or a nursing facility level of care determination must be accepted for purposes
196.27 of initial and ongoing access to waiver services payment.

196.28 (d) Recipients who are found eligible for home and community-based services under
196.29 this section before their 65th birthday may remain eligible for these services after their 65th
196.30 birthday if they continue to meet all other eligibility factors.

196.31 Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

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

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

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

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

197.7 (e) "Direct care staff" means employees providing direct services to an individual
197.8 receiving services under this section. Direct care staff excludes executive, managerial, or
197.9 administrative staff.

197.10 ~~(e)~~ (f) "Disability waiver rates system" means a statewide system that establishes rates
197.11 that are based on uniform processes and captures the individualized nature of waiver services
197.12 and recipient needs.

197.13 ~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to
197.14 an individual recipient by staff to provide direct support and assistance with activities of
197.15 daily living, instrumental activities of daily living, and training to participants, and is based
197.16 on the requirements in each individual's coordinated service and support plan under section
197.17 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
197.18 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
197.19 needs must also be considered.

197.20 ~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged
197.21 with administering waived services under sections 256B.092 and 256B.49.

197.22 ~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups,
197.23 one-half above the median and one-half below the median.

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

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

197.29 ~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded
197.30 under any of the disability waivers.

197.31 ~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph
197.32 (f), providing or available to provide more than one individual with direct support and

198.1 assistance with activities of daily living as defined under section 256B.0659, subdivision
198.2 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659,
198.3 subdivision 1, paragraph (i); ancillary activities needed to support individual services; and
198.4 training to participants, and is based on the requirements in each individual's coordinated
198.5 service and support plan under section 245D.02, subdivision 4b; any coordinated service
198.6 and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and
198.7 provider observation of an individual's service need. Total shared staffing hours are divided
198.8 proportionally by the number of individuals who receive the shared service provisions.

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

198.13 ~~(n)~~ (o) "Unit of service" means the following:

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

198.17 (2) for day services under subdivision 7:

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

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

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

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

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

198.27 (iii) for prevocational services, a unit of service is a day or ~~an hour~~ 15 minutes. A day
198.28 unit of service is six or more hours of time spent providing direct service;

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

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

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

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

199.4 Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

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

199.9 (1) 24-hour customized living;

199.10 (2) adult day care;

199.11 (3) adult day care bath;

199.12 ~~(4) behavioral programming;~~

199.13 ~~(5)~~ (4) companion services;

199.14 ~~(6)~~ (5) customized living;

199.15 ~~(7)~~ (6) day training and habilitation;

199.16 (7) employment development services;

199.17 (8) employment exploration services;

199.18 (9) employment support services;

199.19 ~~(8)~~ (10) housing access coordination;

199.20 ~~(9)~~ (11) independent living skills;

199.21 (12) independent living skills specialist services;

199.22 (13) individualized home supports;

199.23 ~~(10)~~ (14) in-home family support;

199.24 ~~(11)~~ (15) night supervision;

199.25 ~~(12)~~ (16) personal support;

199.26 (17) positive support service;

199.27 ~~(13)~~ (18) prevocational services;

199.28 ~~(14)~~ (19) residential care services;

- 200.1 ~~(15)~~ (20) residential support services;
- 200.2 ~~(16)~~ (21) respite services;
- 200.3 ~~(17)~~ (22) structured day services;
- 200.4 ~~(18)~~ (23) supported employment services;
- 200.5 ~~(19)~~ (24) supported living services;
- 200.6 ~~(20)~~ (25) transportation services; and
- 200.7 ~~(21)~~ individualized home supports;
- 200.8 ~~(22)~~ independent living skills specialist services;
- 200.9 ~~(23)~~ employment exploration services;
- 200.10 ~~(24)~~ employment development services;
- 200.11 ~~(25)~~ employment support services; and
- 200.12 (26) other services as approved by the federal government in the state home and
- 200.13 community-based services plan.

200.14 Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

200.15 Subd. 5. **Base wage index and standard component values.** (a) The base wage index

200.16 is established to determine staffing costs associated with providing services to individuals

200.17 receiving home and community-based services. For purposes of developing and calculating

200.18 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard

200.19 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in

200.20 the most recent edition of the Occupational Handbook must be used. The base wage index

200.21 must be calculated as follows:

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

200.23 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home

200.24 health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC

200.25 code 31-1014); and 20 percent of the median wage for social and human services aide (SOC

200.26 code 21-1093); and

200.27 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide

200.28 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide

200.29 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code

201.1 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
201.2 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);
201.3 (2) for day services, 20 percent of the median wage for nursing assistant (SOC code
201.4 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
201.5 and 60 percent of the median wage for social and human services aide (SOC code 21-1093);
201.6 (3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota
201.7 for large employers, except in a family foster care setting, the wage is 36 percent of the
201.8 minimum wage in Minnesota for large employers;
201.9 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
201.10 counselors (SOC code 21-1014);
201.11 (5) for behavior program professional staff, 100 percent of the median wage for clinical
201.12 counseling and school psychologist (SOC code 19-3031);
201.13 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
201.14 technicians (SOC code 29-2053);
201.15 (7) for supportive living services staff, 20 percent of the median wage for nursing assistant
201.16 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
201.17 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
201.18 21-1093);
201.19 (8) for housing access coordination staff, 100 percent of the median wage for community
201.20 and social services specialist (SOC code 21-1099);
201.21 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
201.22 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
201.23 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
201.24 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
201.25 code 29-2053);
201.26 (10) for individualized home supports services staff, 40 percent of the median wage for
201.27 community social service specialist (SOC code 21-1099); 50 percent of the median wage
201.28 for social and human services aide (SOC code 21-1093); and ten percent of the median
201.29 wage for psychiatric technician (SOC code 29-2053);
201.30 (11) for independent living skills staff, 40 percent of the median wage for community
201.31 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
201.32 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
201.33 technician (SOC code 29-2053);

202.1 (12) for independent living skills specialist staff, 100 percent of mental health and
202.2 substance abuse social worker (SOC code 21-1023);

202.3 (13) for supported employment staff, 20 percent of the median wage for nursing assistant
202.4 (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
202.5 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
202.6 21-1093);

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

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

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

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

202.19 (18) for night supervision staff, 20 percent of the median wage for home health aide
202.20 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
202.21 (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code
202.22 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
202.23 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

202.24 (19) for respite staff, 50 percent of the median wage for personal and home care aide
202.25 (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code
202.26 31-1014);

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

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

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

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

203.5 (b) The commissioner shall adjust the base wage index in paragraph (j) with a competitive
 203.6 workforce factor of 4.7 percent to provide increased compensation to direct care staff. A
 203.7 provider shall use the additional revenue from the competitive workforce factor to increase
 203.8 wages for or to improve benefits provided to direct care staff.

203.9 (c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall
 203.10 report to the chairs and ranking minority members of the legislative committees and divisions
 203.11 with jurisdiction over health and human services policy and finance an analysis of the
 203.12 competitive workforce factor. The report shall include recommendations to adjust the
 203.13 competitive workforce factor using (1) the most recently available wage data by SOC code
 203.14 of the weighted average wage for direct care staff for residential services and direct care
 203.15 staff for day services; (2) the most recently available wage data by SOC code of the weighted
 203.16 average wage of comparable occupations; and (3) labor market data as required under
 203.17 subdivision 10a, paragraph (g). The commissioner shall not recommend in any biennial
 203.18 report an increase or decrease of the competitive workforce factor by more than two
 203.19 percentage points from the current value. If, after a biennial analysis for the next report, the
 203.20 competitive workforce factor is less than or equal to zero, the commissioner shall recommend
 203.21 a competitive workforce factor of zero.

203.22 ~~(b)~~ (d) Component values for residential support services are:

203.23 (1) supervisory span of control ratio: 11 percent;

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

203.25 (3) employee-related cost ratio: 23.6 percent;

203.26 (4) general administrative support ratio: 13.25 percent;

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

203.28 (6) absence and utilization factor ratio: 3.9 percent.

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

203.30 (1) supervisory span of control ratio: 11 percent;

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

- 204.1 (3) employee-related cost ratio: 23.6 percent;
- 204.2 (4) general administrative support ratio: 3.3 percent;
- 204.3 (5) program-related expense ratio: 1.3 percent; and
- 204.4 (6) absence factor: 1.7 percent.
- 204.5 ~~(d)~~ (f) Component values for day services for all services are:
- 204.6 (1) supervisory span of control ratio: 11 percent;
- 204.7 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 204.8 (3) employee-related cost ratio: 23.6 percent;
- 204.9 (4) program plan support ratio: 5.6 percent;
- 204.10 (5) client programming and support ratio: ten percent;
- 204.11 (6) general administrative support ratio: 13.25 percent;
- 204.12 (7) program-related expense ratio: 1.8 percent; and
- 204.13 (8) absence and utilization factor ratio: 9.4 percent.
- 204.14 ~~(e)~~ (g) Component values for unit-based services with programming are:
- 204.15 (1) supervisory span of control ratio: 11 percent;
- 204.16 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 204.17 (3) employee-related cost ratio: 23.6 percent;
- 204.18 (4) program plan supports ratio: 15.5 percent;
- 204.19 (5) client programming and supports ratio: 4.7 percent;
- 204.20 (6) general administrative support ratio: 13.25 percent;
- 204.21 (7) program-related expense ratio: 6.1 percent; and
- 204.22 (8) absence and utilization factor ratio: 3.9 percent.
- 204.23 ~~(f)~~ (h) Component values for unit-based services without programming except respite
- 204.24 are:
- 204.25 (1) supervisory span of control ratio: 11 percent;
- 204.26 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 204.27 (3) employee-related cost ratio: 23.6 percent;

- 205.1 (4) program plan support ratio: 7.0 percent;
- 205.2 (5) client programming and support ratio: 2.3 percent;
- 205.3 (6) general administrative support ratio: 13.25 percent;
- 205.4 (7) program-related expense ratio: 2.9 percent; and
- 205.5 (8) absence and utilization factor ratio: 3.9 percent.
- 205.6 ~~(g)~~ (i) Component values for unit-based services without programming for respite are:
- 205.7 (1) supervisory span of control ratio: 11 percent;
- 205.8 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 205.9 (3) employee-related cost ratio: 23.6 percent;
- 205.10 (4) general administrative support ratio: 13.25 percent;
- 205.11 (5) program-related expense ratio: 2.9 percent; and
- 205.12 (6) absence and utilization factor ratio: 3.9 percent.
- 205.13 ~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph~~
- 205.14 ~~(a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor~~
- 205.15 ~~Statistics available on December 31, 2016. The commissioner shall publish these updated~~
- 205.16 ~~values and load them into the rate management system. (j) On July 1, 2022, and every five~~
- 205.17 ~~two years thereafter, the commissioner shall update the base wage index in paragraph (a)~~
- 205.18 ~~based on the most recently available wage data by SOC from the Bureau of Labor Statistics~~
- 205.19 ~~available 30 months and one day prior to the scheduled update. The commissioner shall~~
- 205.20 ~~publish these updated values and load them into the rate management system.~~
- 205.21 ~~(i) On July 1, 2017, the commissioner shall update the framework components in~~
- 205.22 ~~paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision~~
- 205.23 ~~6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the~~
- 205.24 ~~Consumer Price Index. The commissioner will adjust these values higher or lower by the~~
- 205.25 ~~percentage change in the Consumer Price Index-All Items, United States city average~~
- 205.26 ~~(CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these~~
- 205.27 ~~updated values and load them into the rate management system. (k) On July 1, 2022, and~~
- 205.28 ~~every five two years thereafter, the commissioner shall update the framework components~~
- 205.29 ~~in paragraph (d) (f), clause (5); paragraph (e) (g), clause (5); and paragraph (f) (h), clause~~
- 205.30 ~~(5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for~~
- 205.31 ~~changes in the Consumer Price Index. The commissioner shall adjust these values higher~~
- 205.32 ~~or lower by the percentage change in the CPI-U from the date of the previous update to the~~

206.1 ~~date of the data most recently~~ available 30 months and one day prior to the scheduled update.
 206.2 The commissioner shall publish these updated values and load them into the rate management
 206.3 system.

206.4 (l) Upon the implementation of automatic inflation adjustments under paragraphs (j)
 206.5 and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013,
 206.6 chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall
 206.7 be removed from service rates calculated under this section.

206.8 (m) Any rate adjustments applied to the service rates calculated under this section outside
 206.9 of the cost components and rate methodology specified in this section shall be removed
 206.10 from rate calculations upon implementation of automatic inflation adjustments under
 206.11 paragraphs (j) and (k).

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

206.15 (o) The commissioner shall update the general administrative support ratio in paragraph
 206.16 (d), clause (4); paragraph (e), clause (4); paragraph (f), clause (6); paragraph (g), clause (6);
 206.17 paragraph (h), clause (6); and paragraph (i), clause (4), for any changes to the annual licensing
 206.18 fee under section 245A.10, subdivision 4, paragraph (b). The commissioner shall adjust
 206.19 these ratios higher or lower by an amount equal in value to the percent change in general
 206.20 administrative support costs attributable to the change in the licensing fee. The commissioner
 206.21 shall publish these updated ratios and load them into the rate management system.

206.22 **EFFECTIVE DATE.** This section is effective January 1, 2021, or upon federal approval,
 206.23 whichever is later, except the new paragraphs (b) and (o) are effective January 1, 2020, or
 206.24 upon federal approval, whichever is later. The commissioner of human services shall notify
 206.25 the revisor of statutes when federal approval is obtained.

206.26 Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

206.27 **Subd. 6. Payments for residential support services.** (a) Payments for residential support
 206.28 services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22,
 206.29 must be calculated as follows:

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

207.1 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
207.2 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
207.3 5. This is defined as the direct-care rate;

207.4 (3) for a recipient requiring customization for deaf and hard-of-hearing language
207.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
207.6 to the result of clause (2). This is defined as the customized direct-care rate;

207.7 (4) multiply the number of shared and individual direct staff hours provided on site or
207.8 through monitoring technology and nursing hours by the appropriate staff wages in
207.9 subdivision 5, paragraph (a), or the customized direct-care rate;

207.10 (5) multiply the number of shared and individual direct staff hours provided on site or
207.11 through monitoring technology and nursing hours by the product of the supervision span
207.12 of control ratio in subdivision 5, paragraph ~~(b)~~ (d), clause (1), and the appropriate supervision
207.13 wage in subdivision 5, paragraph (a), clause (21);

207.14 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
207.15 staff hours provided through monitoring technology, and multiply the result by one plus
207.16 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(b)~~
207.17 (d), clause (2). This is defined as the direct staffing cost;

207.18 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
207.19 and individual direct staff hours provided through monitoring technology, by one plus the
207.20 employee-related cost ratio in subdivision 5, paragraph ~~(b)~~ (d), clause (3);

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

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

207.24 (b) The total rate must be calculated using the following steps:

207.25 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared
207.26 and individual direct staff hours provided through monitoring technology that was excluded
207.27 in clause (7);

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

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

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

208.3 (c) The payment methodology for customized living, 24-hour customized living, and
208.4 residential care services must be the customized living tool. Revisions to the customized
208.5 living tool must be made to reflect the services and activities unique to disability-related
208.6 recipient needs.

208.7 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
208.8 meet or exceed the days of service used to convert service agreements in effect on December
208.9 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
208.10 during the implementation period under section 256B.4913, subdivision 4a. If during the
208.11 implementation period, an individual's historical rate, including adjustments required under
208.12 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
208.13 determined in this subdivision, the number of days authorized for the individual is 365.

208.14 (e) The number of days authorized for all individuals enrolling after January 1, 2014,
208.15 in residential services must include every day that services start and end.

208.16 Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

208.17 Subd. 7. **Payments for day programs.** Payments for services with day programs
208.18 including adult day care, day treatment and habilitation, prevocational services, and structured
208.19 day services must be calculated as follows:

208.20 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

208.21 (i) the staffing ratios for the units of service provided to a recipient in a typical week
208.22 must be averaged to determine an individual's staffing ratio; and

208.23 (ii) the commissioner, in consultation with service providers, shall develop a uniform
208.24 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

208.25 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
208.26 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
208.27 5;

208.28 (3) for a recipient requiring customization for deaf and hard-of-hearing language
208.29 accessibility under subdivision 12, add the customization rate provided in subdivision 12
208.30 to the result of clause (2). This is defined as the customized direct-care rate;

208.31 (4) multiply the number of day program direct staff hours and nursing hours by the
208.32 appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

209.1 (5) multiply the number of day direct staff hours by the product of the supervision span
209.2 of control ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (1), and the appropriate supervision
209.3 wage in subdivision 5, paragraph (a), clause (21);

209.4 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
209.5 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (f),
209.6 clause (2). This is defined as the direct staffing rate;

209.7 (7) for program plan support, multiply the result of clause (6) by one plus the program
209.8 plan support ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (4);

209.9 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
209.10 employee-related cost ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (3);

209.11 (9) for client programming and supports, multiply the result of clause (8) by one plus
209.12 the client programming and support ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (5);

209.13 (10) for program facility costs, add \$19.30 per week with consideration of staffing ratios
209.14 to meet individual needs;

209.15 (11) for adult day bath services, add \$7.01 per 15 minute unit;

209.16 (12) this is the subtotal rate;

209.17 (13) sum the standard general and administrative rate, the program-related expense ratio,
209.18 and the absence and utilization factor ratio;

209.19 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
209.20 total payment amount;

209.21 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
209.22 to adjust for regional differences in the cost of providing services;

209.23 (16) for transportation provided as part of day training and habilitation for an individual
209.24 who does not require a lift, add:

209.25 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
209.26 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
209.27 vehicle with a lift;

209.28 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
209.29 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
209.30 vehicle with a lift;

210.1 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
210.2 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
210.3 vehicle with a lift; or

210.4 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
210.5 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
210.6 with a lift;

210.7 (17) for transportation provided as part of day training and habilitation for an individual
210.8 who does require a lift, add:

210.9 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
210.10 lift, and \$15.05 for a shared ride in a vehicle with a lift;

210.11 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
210.12 lift, and \$28.16 for a shared ride in a vehicle with a lift;

210.13 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
210.14 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

210.15 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
210.16 and \$80.93 for a shared ride in a vehicle with a lift.

210.17 Sec. 40. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

210.18 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
210.19 services with programming, including behavior programming, housing access coordination,
210.20 in-home family support, independent living skills training, independent living skills specialist
210.21 services, individualized home supports, hourly supported living services, employment
210.22 exploration services, employment development services, supported employment, and
210.23 employment support services provided to an individual outside of any day or residential
210.24 service plan must be calculated as follows, unless the services are authorized separately
210.25 under subdivision 6 or 7:

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

210.27 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
210.28 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
210.29 5;

210.30 (3) for a recipient requiring customization for deaf and hard-of-hearing language
210.31 accessibility under subdivision 12, add the customization rate provided in subdivision 12
210.32 to the result of clause (2). This is defined as the customized direct-care rate;

211.1 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
211.2 5, paragraph (a), or the customized direct-care rate;

211.3 (5) multiply the number of direct staff hours by the product of the supervision span of
211.4 control ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (1), and the appropriate supervision
211.5 wage in subdivision 5, paragraph (a), clause (21);

211.6 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
211.7 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(e)~~ (g),
211.8 clause (2). This is defined as the direct staffing rate;

211.9 (7) for program plan support, multiply the result of clause (6) by one plus the program
211.10 plan supports ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (4);

211.11 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
211.12 employee-related cost ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (3);

211.13 (9) for client programming and supports, multiply the result of clause (8) by one plus
211.14 the client programming and supports ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (5);

211.15 (10) this is the subtotal rate;

211.16 (11) sum the standard general and administrative rate, the program-related expense ratio,
211.17 and the absence and utilization factor ratio;

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

211.20 (13) for supported employment provided in a shared manner, divide the total payment
211.21 amount in clause (12) by the number of service recipients, not to exceed three. For
211.22 employment support services provided in a shared manner, divide the total payment amount
211.23 in clause (12) by the number of service recipients, not to exceed six. For independent living
211.24 skills training and individualized home supports provided in a shared manner, divide the
211.25 total payment amount in clause (12) by the number of service recipients, not to exceed two;
211.26 and

211.27 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
211.28 to adjust for regional differences in the cost of providing services.

211.29 Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

211.30 Subd. 9. **Payments for unit-based services without programming.** Payments for
211.31 unit-based services without programming, including night supervision, personal support,
211.32 respite, and companion care provided to an individual outside of any day or residential

- 212.1 service plan must be calculated as follows unless the services are authorized separately
212.2 under subdivision 6 or 7:
- 212.3 (1) for all services except respite, determine the number of units of service to meet a
212.4 recipient's needs;
- 212.5 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
212.6 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
- 212.7 (3) for a recipient requiring customization for deaf and hard-of-hearing language
212.8 accessibility under subdivision 12, add the customization rate provided in subdivision 12
212.9 to the result of clause (2). This is defined as the customized direct care rate;
- 212.10 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
212.11 5 or the customized direct care rate;
- 212.12 (5) multiply the number of direct staff hours by the product of the supervision span of
212.13 control ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (1), and the appropriate supervision
212.14 wage in subdivision 5, paragraph (a), clause (21);
- 212.15 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
212.16 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (h),
212.17 clause (2). This is defined as the direct staffing rate;
- 212.18 (7) for program plan support, multiply the result of clause (6) by one plus the program
212.19 plan support ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (4);
- 212.20 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
212.21 employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (3);
- 212.22 (9) for client programming and supports, multiply the result of clause (8) by one plus
212.23 the client programming and support ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (5);
- 212.24 (10) this is the subtotal rate;
- 212.25 (11) sum the standard general and administrative rate, the program-related expense ratio,
212.26 and the absence and utilization factor ratio;
- 212.27 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
212.28 total payment amount;
- 212.29 (13) for respite services, determine the number of day units of service to meet an
212.30 individual's needs;

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

213.3 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
 213.4 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
 213.5 is defined as the customized direct care rate;

213.6 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
 213.7 5, paragraph (a);

213.8 (17) multiply the number of direct staff hours by the product of the supervisory span of
 213.9 control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (1), and the appropriate supervision
 213.10 wage in subdivision 5, paragraph (a), clause (21);

213.11 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
 213.12 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~
 213.13 (i), clause (2). This is defined as the direct staffing rate;

213.14 (19) for employee-related expenses, multiply the result of clause (18) by one plus the
 213.15 employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (3);

213.16 (20) this is the subtotal rate;

213.17 (21) sum the standard general and administrative rate, the program-related expense ratio,
 213.18 and the absence and utilization factor ratio;

213.19 (22) divide the result of clause (20) by one minus the result of clause (21). This is the
 213.20 total payment amount; and

213.21 (23) adjust the result of clauses (12) and (22) by a factor to be determined by the
 213.22 commissioner to adjust for regional differences in the cost of providing services.

213.23 Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

213.24 Subd. 10. **Updating payment values and additional information.** ~~(a) From January~~
 213.25 ~~1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform~~
 213.26 ~~procedures to refine terms and adjust values used to calculate payment rates in this section.~~

213.27 ~~(b)~~ (a) No later than July 1, 2014, the commissioner shall, within available resources,
 213.28 begin to conduct research and gather data and information from existing state systems or
 213.29 other outside sources on the following items:

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

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

214.4 (3) the distinct underlying costs for services provided by a license holder under sections
 214.5 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
 214.6 by a license holder certified under section 245D.33.

214.7 ~~(e) Beginning January 1, 2014, through December 31, 2018, using a statistically valid~~
 214.8 ~~set of rates management system data, the commissioner, in consultation with stakeholders,~~
 214.9 ~~shall analyze for each service the average difference in the rate on December 31, 2013, and~~
 214.10 ~~the framework rate at the individual, provider, lead agency, and state levels. The~~
 214.11 ~~commissioner shall issue semiannual reports to the stakeholders on the difference in rates~~
 214.12 ~~by service and by county during the banding period under section 256B.4913, subdivision~~
 214.13 ~~4a. The commissioner shall issue the first report by October 1, 2014, and the final report~~
 214.14 ~~shall be issued by December 31, 2018.~~

214.15 ~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders,
 214.16 shall begin the review and evaluation of the following values already in subdivisions ~~6~~ 5 to
 214.17 9, or issues that impact all services, including, but not limited to:

214.18 (1) values for transportation rates;

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

214.20 (3) values for indirect services;

214.21 (4) values for nursing;

214.22 (5) values for the facility use rate in day services, and the weightings used in the day
 214.23 service ratios and adjustments to those weightings;

214.24 (6) values for workers' compensation as part of employee-related expenses;

214.25 (7) values for unemployment insurance as part of employee-related expenses;

214.26 (8) direct care workforce labor market measures;

214.27 (9) any changes in state or federal law with a direct impact on the underlying cost of
 214.28 providing home and community-based services; ~~and~~

214.29 ~~(9)~~ (10) outcome measures, determined by the commissioner, for home and
 214.30 community-based services rates determined under this section; ~~and~~

214.31 (11) different competitive workforce factors by service.

215.1 ~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members
 215.2 of the legislative committees and divisions with jurisdiction over health and human services
 215.3 policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a)
 215.4 and (b) on ~~the following dates:~~

215.5 ~~(1) January 15, 2015, with preliminary results and data;~~

215.6 ~~(2) January 15, 2016, with a status implementation update, and additional data and~~
 215.7 ~~summary information;~~

215.8 ~~(3) January 15, 2017, with the full report; and~~

215.9 ~~(4) January 15, 2020~~ 2021, with another full report, and a full report once every four
 215.10 years thereafter.

215.11 ~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations~~
 215.12 ~~in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~
 215.13 January 1, 2022, the commissioner shall renew analysis and implement changes to the
 215.14 regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h),~~
 215.15 ~~occur~~ once every six years. Prior to implementation, the commissioner shall consult with
 215.16 stakeholders on the methodology to calculate the adjustment.

215.17 ~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of
 215.18 each year beginning October 1, 2014, containing information detailing legislatively approved
 215.19 changes in:

215.20 (1) calculation values including derived wage rates and related employee and
 215.21 administrative factors;

215.22 (2) service utilization;

215.23 (3) county and tribal allocation changes; and

215.24 (4) information on adjustments made to calculation values and the timing of those
 215.25 adjustments.

215.26 The information in this notice must be effective January 1 of the following year.

215.27 ~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient
 215.28 to meet the needs of an individual who enrolled in residential services after January 1, 2014,
 215.29 or insufficient to meet the needs of an individual with a service agreement adjustment
 215.30 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
 215.31 shall be used.

216.1 ~~(i) The commissioner shall study the underlying cost of absence and utilization for day~~
 216.2 ~~services. Based on the commissioner's evaluation of the data collected under this paragraph,~~
 216.3 ~~the commissioner shall make recommendations to the legislature by January 15, 2018, for~~
 216.4 ~~changes, if any, to the absence and utilization factor ratio component value for day services.~~

216.5 ~~(j)~~ (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip
 216.6 information for all day services through the rates management system.

216.7 (h) The commissioner, in consultation with stakeholders, shall study value-based models
 216.8 and outcome-based payment strategies for fee-for-service home and community-based
 216.9 services and report to the legislative committees with jurisdiction over the disability waiver
 216.10 rate system by October 1, 2020, with recommended strategies to improve the quality,
 216.11 efficiency, and effectiveness of services.

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

216.13 Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to
 216.14 read:

216.15 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
 216.16 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 216.17 service. As determined by the commissioner, in consultation with stakeholders identified
 216.18 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
 216.19 determined under this section must submit requested cost data to the commissioner to support
 216.20 research on the cost of providing services that have rates determined by the disability waiver
 216.21 rates system. Requested cost data may include, but is not limited to:

216.22 (1) worker wage costs;

216.23 (2) benefits paid;

216.24 (3) supervisor wage costs;

216.25 (4) executive wage costs;

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

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

216.28 (7) administrative costs paid;

216.29 (8) program costs paid;

216.30 (9) transportation costs paid;

216.31 (10) vacancy rates; and

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

217.3 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
217.4 year that ended not more than 18 months prior to the submission date. The commissioner
217.5 shall provide each provider a 90-day notice prior to its submission due date. If a provider
217.6 fails to submit required reporting data, the commissioner shall provide notice to providers
217.7 that have not provided required data 30 days after the required submission date, and a second
217.8 notice for providers who have not provided required data 60 days after the required
217.9 submission date. The commissioner shall temporarily suspend payments to the provider if
217.10 cost data is not received 90 days after the required submission date. Withheld payments
217.11 shall be made once data is received by the commissioner.

217.12 (c) The commissioner shall conduct a random validation of data submitted under
217.13 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
217.14 in paragraph (a) and provide recommendations for adjustments to cost components.

217.15 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
217.16 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
217.17 recommendations on component values and inflationary factor adjustments to the chairs
217.18 and ranking minority members of the legislative committees with jurisdiction over human
217.19 services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make
217.20 recommendations in conjunction with reports submitted to the legislature according to
217.21 subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate
217.22 form, and cost data from individual providers shall not be released except as provided for
217.23 in current law.

217.24 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
217.25 subdivision 5, shall develop and implement a process for providing training and technical
217.26 assistance necessary to support provider submission of cost documentation required under
217.27 paragraph (a).

217.28 (f) By December 31, 2020, providers paid with rates calculated under subdivision 5,
217.29 paragraph (b), shall identify additional revenues from the competitive workforce factor and
217.30 prepare a written distribution plan for the revenues. A provider shall make the provider's
217.31 distribution plan available and accessible to all direct care staff for a minimum of one
217.32 calendar year. Upon request, a provider shall submit the written distribution plan to the
217.33 commissioner.

218.1 (g) Providers enrolled to provide services with rates determined under section 256B.4914,
 218.2 subdivision 3, shall submit labor market data to the commissioner annually on or before
 218.3 November 1, including but not limited to:

218.4 (1) number of direct care staff;

218.5 (2) wages of direct care staff;

218.6 (3) overtime wages of direct care staff;

218.7 (4) hours worked by direct care staff;

218.8 (5) overtime hours worked by direct care staff;

218.9 (6) benefits provided to direct care staff;

218.10 (7) direct care staff job vacancies; and

218.11 (8) direct care staff retention rates.

218.12 (h) The commissioner shall publish annual reports on provider and state-level labor
 218.13 market data, including but not limited to the data obtained under paragraph (g).

218.14 (i) The commissioner shall temporarily suspend payments to the provider if data requested
 218.15 under paragraph (g) is not received 90 days after the required submission date. Withheld
 218.16 payments shall be made once data is received by the commissioner.

218.17 **EFFECTIVE DATE.** This section is effective the day following final enactment except
 218.18 paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1,
 218.19 2020.

218.20 Sec. 44. Minnesota Statutes 2018, section 256B.493, subdivision 1, is amended to read:

218.21 Subdivision 1. **Commissioner's duties; report.** The commissioner of human services
 218.22 has the authority to manage statewide licensed corporate foster care or community residential
 218.23 settings capacity, including the reduction and realignment of licensed capacity of a current
 218.24 foster care or community residential setting to accomplish the consolidation or closure of
 218.25 settings. The commissioner shall implement a program for planned closure of licensed
 218.26 corporate adult foster care or community residential settings, necessary as a preferred method
 218.27 to: (1) respond to the informed decisions of those individuals who want to move out of these
 218.28 settings into other types of community settings; and (2) achieve ~~necessary budgetary savings~~
 218.29 the reduction of statewide licensed capacity required in section 245A.03, subdivision 7,
 218.30 paragraphs (c) and (d). Closure determinations by the commissioner are final and not subject
 218.31 to appeal.

219.1 Sec. 45. Minnesota Statutes 2018, section 256B.5013, subdivision 1, is amended to read:

219.2 Subdivision 1. **Variable rate adjustments.** (a) ~~For rate years beginning on or after~~
 219.3 ~~October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD
 219.4 recipient, the county of financial responsibility may recommend a variable rate to enable
 219.5 the facility to meet the individual's increased needs. Variable rate adjustments made under
 219.6 this subdivision replace payments for persons with special needs for crisis intervention
 219.7 services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a~~
 219.8 ~~base rate above the 50th percentile of the statewide average reimbursement rate for a Class~~
 219.9 ~~A facility or Class B facility, whichever matches the facility licensure, are not eligible for~~
 219.10 ~~a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,~~
 219.11 ~~except when approved for purposes established in paragraph (b), clause (1).~~ Once approved,
 219.12 variable rate adjustments must continue to remain in place unless there is an identified
 219.13 change in need. A review of needed resources must be done at the time of the individual's
 219.14 annual support plan meeting. A request to adjust the resources of the individual must be
 219.15 submitted if any change in need is identified. Variable rate adjustments approved solely on
 219.16 the basis of changes on a developmental disabilities screening document will end June 30,
 219.17 2002.

219.18 (b) The county of financial responsibility must act on a variable rate request within 30
 219.19 days and notify the initiator of the request of the county's recommendation in writing.

219.20 ~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility
 219.21 for increased needs in the following situations:

219.22 (1) a need for resources due to an individual's full or partial retirement from participation
 219.23 in a day training and habilitation service when the individual: (i) has reached the age of 65
 219.24 or has a change in health condition that makes it difficult for the person to participate in
 219.25 day training and habilitation services over an extended period of time because it is medically
 219.26 contraindicated; and (ii) has expressed a desire for change through the developmental
 219.27 disability screening process under section 256B.092;

219.28 (2) a need for additional resources for intensive short-term programming which is
 219.29 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

219.30 (3) a demonstrated medical need that significantly impacts the type or amount of services
 219.31 needed by the individual; ~~or~~

219.32 (4) a demonstrated behavioral or cognitive need that significantly impacts the type or
 219.33 amount of services needed by the individual; or

220.1 ~~(e) The county of financial responsibility must justify the purpose, the projected length~~
 220.2 ~~of time, and the additional funding needed for the facility to meet the needs of the individual.~~

220.3 ~~(d) The facility shall provide an annual report to the county case manager on the use of~~
 220.4 ~~the variable rate funds and the status of the individual on whose behalf the funds were~~
 220.5 ~~approved. The county case manager will forward the facility's report with a recommendation~~
 220.6 ~~to the commissioner to approve or disapprove a continuation of the variable rate.~~

220.7 ~~(e) Funds made available through the variable rate process that are not used by the facility~~
 220.8 ~~to meet the needs of the individual for whom they were approved shall be returned to the~~
 220.9 ~~state.~~

220.10 (5) a demonstrated increased need for staff assistance, changes in the type of staff
 220.11 credentials needed, or a need for expert consultation based on assessments conducted prior
 220.12 to the annual support plan meeting.

220.13 (d) Variable rate requests must include the following information:

220.14 (1) the service needs change;

220.15 (2) the variable rate requested and the difference from the current rate;

220.16 (3) a basis for the underlying costs used for the variable rate and any accompanying
 220.17 documentation; and

220.18 (4) documentation of the expected outcomes to be achieved and the frequency of progress
 220.19 monitoring associated with the rate increase.

220.20 **EFFECTIVE DATE.** This section is effective July 1, 2019, or upon federal approval,
 220.21 whichever is later. The commissioner of human services shall inform the revisor of statutes
 220.22 when federal approval is obtained.

220.23 Sec. 46. Minnesota Statutes 2018, section 256B.5013, subdivision 6, is amended to read:

220.24 Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

220.25 (1) make a determination to approve, deny, or modify a request for a variable rate
 220.26 adjustment within 30 days of the receipt of the completed application;

220.27 (2) notify the ICF/DD facility and county case manager of the ~~duration and conditions~~
 220.28 ~~of variable rate adjustment approvals~~ determination; and

220.29 (3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved
 220.30 variable rates.

221.1 Sec. 47. Minnesota Statutes 2018, section 256B.5015, subdivision 2, is amended to read:

221.2 Subd. 2. **Services during the day.** (a) Services during the day, as defined in section
 221.3 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through
 221.4 payment no later than January 1, 2004. The commissioner shall establish rates for these
 221.5 services, other than day training and habilitation services, at levels that do not exceed 75
 221.6 100 percent of a recipient's day training and habilitation service costs prior to the service
 221.7 change.

221.8 (b) An individual qualifies for services during the day under paragraph (a) if:

221.9 (1) through consultation with the individual and their support team or interdisciplinary
 221.10 team, it has been determined that the individual's needs can best be met through partial or
 221.11 full retirement from:

221.12 (i) participation in a day training and habilitation service; or

221.13 (ii) the use of services during the day in the individual's home environment; and

221.14 (2) in consultation with the individual and their support team or interdisciplinary team,
 221.15 an individualized plan has been developed with designated outcomes that:

221.16 (i) addresses the support needs and desires contained in the person-centered plan or
 221.17 individual support plan; and

221.18 (ii) includes goals that focus on community integration as appropriate for the individual.

221.19 (c) When establishing a rate for these services, the commissioner shall also consider an
 221.20 individual recipient's needs as identified in the ~~individualized service~~ individual support
 221.21 plan and the person's need for active treatment as defined under federal regulations. The
 221.22 pass-through payments for services during the day shall be paid separately by the
 221.23 commissioner and shall not be included in the computation of the ICF/DD facility total
 221.24 payment rate.

221.25 Sec. 48. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

221.26 Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

221.27 (1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056,
 221.28 or 256B.057, subdivisions 5 and 9;

221.29 (2) is a participant in the alternative care program under section 256B.0913;

221.30 (3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or
 221.31 256B.49; or

222.1 (4) has medical services identified in a person's individualized education program and
 222.2 is eligible for services as determined in section 256B.0625, subdivision 26.

222.3 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
 222.4 meet all of the following:

222.5 (1) based on an assessment under section 256B.0911, require assistance and be determined
 222.6 dependent in one critical activity of daily living or one Level I behavior based on assessment
 222.7 under section 256B.0911 or have a behavior that shows increased vulnerability due to
 222.8 cognitive deficits or socially inappropriate behavior that requires assistance at least four
 222.9 times per week; and

222.10 (2) is not a participant under a family support grant under section 252.32.

222.11 (c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision
 222.12 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible
 222.13 for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as
 222.14 determined under section 256B.0911.

222.15 Sec. 49. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

222.16 Subd. 8. **Determination of CFSS service authorization amount.** (a) All community
 222.17 first services and supports must be authorized by the commissioner or the commissioner's
 222.18 designee before services begin. The authorization for CFSS must be completed as soon as
 222.19 possible following an assessment but no later than 40 calendar days from the date of the
 222.20 assessment.

222.21 (b) The amount of CFSS authorized must be based on the participant's home care rating
 222.22 described in paragraphs (d) and (e) and any additional service units for which the participant
 222.23 qualifies as described in paragraph (f).

222.24 (c) The home care rating shall be determined by the commissioner or the commissioner's
 222.25 designee based on information submitted to the commissioner identifying the following for
 222.26 a participant:

222.27 (1) the total number of dependencies of activities of daily living;

222.28 (2) the presence of complex health-related needs; and

222.29 (3) the presence of Level I behavior.

222.30 (d) The methodology to determine the total service units for CFSS for each home care
 222.31 rating is based on the median paid units per day for each home care rating from fiscal year
 222.32 2007 data for the PCA program.

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

223.3 (1) ~~P~~ LT home care rating requires ~~Level I behavior or one to three dependencies in~~
 223.4 ~~ADLs and qualifies the person for five service units~~ the presence of increased vulnerability
 223.5 due to cognitive deficits and socially inappropriate behavior that requires assistance at least
 223.6 four times per week, the presence of a Level I behavior, or a dependency in one critical
 223.7 activity of daily living, and qualifies the person for two service units;

223.8 (2) P home care rating requires two to three dependencies in ADLs, one of which must
 223.9 be a critical ADL, and qualifies the person for five services units;

223.10 (3) Q home care rating requires Level I behavior and ~~one~~ two to three dependencies in
 223.11 ADLs, one of which must be a critical ADL, and qualifies the person for six service units;

223.12 ~~(3)~~ (4) R home care rating requires a complex health-related need and ~~one~~ two to three
 223.13 dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for
 223.14 seven service units;

223.15 ~~(4)~~ (5) S home care rating requires four to six dependencies in ADLs, one of which must
 223.16 be a critical ADL, and qualifies the person for ten service units;

223.17 ~~(5)~~ (6) T home care rating requires Level I behavior and four to six dependencies in
 223.18 ADLs and ~~Level I behavior~~, one of which must be a critical ADL, and qualifies the person
 223.19 for 11 service units;

223.20 ~~(6)~~ (7) U home care rating requires four to six dependencies in ADLs, one of which
 223.21 must be a critical ADL, and a complex health-related need and qualifies the person for 14
 223.22 service units;

223.23 ~~(7)~~ (8) V home care rating requires seven to eight dependencies in ADLs and qualifies
 223.24 the person for 17 service units;

223.25 ~~(8)~~ (9) W home care rating requires seven to eight dependencies in ADLs and Level I
 223.26 behavior and qualifies the person for 20 service units;

223.27 ~~(9)~~ (10) Z home care rating requires seven to eight dependencies in ADLs and a complex
 223.28 health-related need and qualifies the person for 30 service units; and

223.29 ~~(10)~~ (11) EN home care rating includes ventilator dependency as defined in section
 223.30 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of
 223.31 ventilator-dependent and the EN home care rating and utilize a combination of CFSS and
 223.32 home care nursing services is limited to a total of 96 service units per day for those services

224.1 in combination. Additional units may be authorized when a person's assessment indicates
 224.2 a need for two staff to perform activities. Additional time is limited to 16 service units per
 224.3 day.

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

224.6 (1) 30 additional minutes per day for a dependency in each critical activity of daily
 224.7 living;

224.8 (2) 30 additional minutes per day for each complex health-related need; and

224.9 (3) 30 additional minutes per day when the behavior requires assistance at least four
 224.10 times per week for one or more of the following behaviors:

224.11 (i) level I behavior;

224.12 (ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior;
 224.13 or

224.14 (iii) increased need for assistance for participants who are verbally aggressive or resistive
 224.15 to care so that the time needed to perform activities of daily living is increased.

224.16 (g) The service budget for budget model participants shall be based on:

224.17 (1) assessed units as determined by the home care rating; and

224.18 (2) an adjustment needed for administrative expenses.

224.19 Sec. 50. Minnesota Statutes 2018, section 256C.23, is amended by adding a subdivision
 224.20 to read:

224.21 Subd. 7. **Family and community intervener.** "Family and community intervener"
 224.22 means a paraprofessional, specifically trained in deafblindness, who works one-on-one with
 224.23 a child who is deafblind to provide critical connections to people and the environment.

224.24 Sec. 51. Minnesota Statutes 2018, section 256C.261, is amended to read:

224.25 **256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND.**

224.26 (a) The commissioner of human services shall use at least 35 percent of the deafblind
 224.27 services biennial base level grant funding for services and other supports for a child who is
 224.28 deafblind and the child's family. The commissioner shall use at least 25 percent of the
 224.29 deafblind services biennial base level grant funding for services and other supports for an
 224.30 adult who is deafblind.

225.1 The commissioner shall award grants for the purposes of:

225.2 (1) providing services and supports to persons who are deafblind; and

225.3 (2) developing and providing training to counties and the network of senior citizen
 225.4 service providers. The purpose of the training grants is to teach counties how to use existing
 225.5 programs that capture federal financial participation to meet the needs of eligible persons
 225.6 who are deafblind and to build capacity of senior service programs to meet the needs of
 225.7 seniors with a dual sensory hearing and vision loss.

225.8 (b) The commissioner may make grants:

225.9 (1) for services and training provided by organizations; and

225.10 (2) to develop and administer consumer-directed services.

225.11 (c) Consumer-directed services shall be provided in whole by grant-funded providers.
 225.12 The Deaf and Hard-of-Hearing Services Division's regional service centers shall not provide
 225.13 any aspect of a grant-funded consumer-directed services program.

225.14 (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under
 225.15 paragraph (a).

225.16 (e) Deafblind service providers may, but are not required to, provide intervenor services
 225.17 as part of the service package provided with grant funds under this section. Intervener
 225.18 services include services provided by a family and community intervenor as described in
 225.19 paragraph (f).

225.20 (f) The family and community intervenor, as defined in section 256C.23, subdivision 7,
 225.21 provides services to open channels of communication between the child and others; facilitate
 225.22 the development or use of receptive and expressive communication skills by the child; and
 225.23 develop and maintain a trusting, interactive relationship that promotes social and emotional
 225.24 well-being. The family and community intervenor also provides access to information and
 225.25 the environment, and facilitates opportunities for learning and development. A family and
 225.26 community intervenor must have specific training in deafblindness, building language and
 225.27 communication skills, and intervention strategies.

225.28 Sec. 52. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

225.29 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
 225.30 services provided to individuals in addition to room and board including, but not limited
 225.31 to, oversight and up to 24-hour supervision, medication reminders, assistance with

226.1 transportation, arranging for meetings and appointments, and arranging for medical and
226.2 social services, and services identified in section 256I.03, subdivision 12.

226.3 Sec. 53. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

226.4 Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers
226.5 of housing support must be in writing on a form developed and approved by the commissioner
226.6 and must specify the name and address under which the establishment subject to the
226.7 agreement does business and under which the establishment, or service provider, if different
226.8 from the group residential housing establishment, is licensed by the Department of Health
226.9 or the Department of Human Services; the specific license or registration from the
226.10 Department of Health or the Department of Human Services held by the provider and the
226.11 number of beds subject to that license; the address of the location or locations at which
226.12 group residential housing is provided under this agreement; the per diem and monthly rates
226.13 that are to be paid from housing support funds for each eligible resident at each location;
226.14 the number of beds at each location which are subject to the agreement; whether the license
226.15 holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code;
226.16 and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06
226.17 and subject to any changes to those sections.

226.18 (b) Providers are required to verify the following minimum requirements in the
226.19 agreement:

226.20 (1) current license or registration, including authorization if managing or monitoring
226.21 medications;

226.22 (2) all staff who have direct contact with recipients meet the staff qualifications;

226.23 (3) the provision of housing support;

226.24 (4) the provision of supplementary services, if applicable;

226.25 (5) reports of adverse events, including recipient death or serious injury; ~~and~~

226.26 (6) submission of residency requirements that could result in recipient eviction; and

226.27 (7) confirmation that the provider will not limit or restrict the number of hours an
226.28 applicant or recipient chooses to be employed, as specified in subdivision 5.

226.29 (c) Agreements may be terminated with or without cause by the commissioner, the
226.30 agency, or the provider with two calendar months prior notice. The commissioner may
226.31 immediately terminate an agreement under subdivision 2d.

227.1 Sec. 54. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
227.2 to read:

227.3 Subd. 2h. **Required supplementary services.** Providers of supplementary services shall
227.4 ensure that recipients have, at a minimum, assistance with services as identified in the
227.5 recipient's professional statement of need under section 256I.03, subdivision 12. Providers
227.6 of supplementary services shall maintain case notes with the date and description of services
227.7 provided to individual recipients.

227.8 Sec. 55. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision
227.9 to read:

227.10 Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number
227.11 of hours an applicant or recipient is employed.

227.12 Sec. 56. Minnesota Statutes 2018, section 256I.05, subdivision 1r, is amended to read:

227.13 Subd. 1r. **Supplemental rate; Anoka County.** (a) Notwithstanding the provisions in
227.14 this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to
227.15 the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
227.16 1a, including any legislatively authorized inflationary adjustments, for a housing support
227.17 provider that is located in Anoka County and provides emergency housing on the former
227.18 Anoka Regional Treatment Center campus.

227.19 (b) Notwithstanding the provisions in this section, a county agency shall negotiate a
227.20 supplemental rate for six beds in addition to the rate specified in subdivision 1, not to exceed
227.21 the maximum rate allowed under subdivision 1a, including any legislatively authorized
227.22 inflationary adjustments, for a housing support provider located in Anoka County that
227.23 operates a 12-bed facility and provides room and board and supplementary services to
227.24 individuals 18 to 24 years of age.

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

227.26 Sec. 57. **[268A.061] HOME AND COMMUNITY-BASED PROVIDERS.**

227.27 Subdivision 1. **Home and community-based provider eligibility for**
227.28 **payments.** Notwithstanding Minnesota Rules, part 3300.5060, subparts 14 to 16, the
227.29 commissioner shall make payments for job-related services, vocational adjustment training,
227.30 and vocational evaluation services to any home and community-based services provider
227.31 licensed as an intensive support services provider under chapter 245D with whom the
227.32 commissioner has signed a limited-use vendor operating agreement.

228.1 Subd. 2. Limited-use agreements with home and community-based providers. A
 228.2 limited-use vendor operating agreement under this section may not limit the dollar amount
 228.3 the provider may receive annually. The limited-use vendor operating agreement available
 228.4 under this section must specify at a minimum that payments under the agreement are limited
 228.5 to vocational rehabilitation services provided to individuals to whom the provider has
 228.6 previously provided day services as described under section 245D.03, subdivision 1,
 228.7 paragraph (c), clause (4), or any of the employment services described under section 245D.03,
 228.8 subdivision 1, paragraph (c), clauses (5) to (7).

228.9 Subd. 3. Required limited-use agreements. The commissioner must enter into a
 228.10 limited-use vendor operating agreement that meets at least the minimal requirements of
 228.11 subdivision 2 with a provider eligible under subdivision 1 if:

228.12 (1) the home and community-based provider is not a current vocational rehabilitation
 228.13 services provider;

228.14 (2) each individual to be served under the limited-use vendor operating agreement was
 228.15 receiving day or employment services from the provider immediately prior to the provider
 228.16 serving the individual under the terms of the agreement; and

228.17 (3) each individual to be served under the limited-use vendor operating agreement has
 228.18 made an informed choice to remain with the provider.

228.19 Sec. 58. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to
 228.20 read:

228.21 **Sec. 44. EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
 228.22 **BUDGET METHODOLOGY EXCEPTION.**

228.23 (a) No later than September 30, 2017, if necessary, the commissioner of human services
 228.24 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
 228.25 and community-based services waivers authorized under Minnesota Statutes, sections
 228.26 256B.092 and 256B.49, to expand the exception to the consumer-directed community
 228.27 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide
 228.28 up to 30 percent more funds for either:

228.29 (1) consumer-directed community supports participants who have a coordinated service
 228.30 and support plan which identifies the need for an increased amount of services or supports
 228.31 under consumer-directed community supports than the amount they are currently receiving
 228.32 under the consumer-directed community supports budget methodology:

229.1 (i) to increase the amount of time a person works or otherwise improves employment
229.2 opportunities;

229.3 (ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes,
229.4 section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or paragraph (g), clause~~
229.5 (1), item (iii); or

229.6 (iii) to develop and implement a positive behavior support plan; or

229.7 (2) home and community-based waiver participants who are currently using licensed
229.8 providers for (i) employment supports or services during the day; or (ii) residential services,
229.9 either of which cost more annually than the person would spend under a consumer-directed
229.10 community supports plan for any or all of the supports needed to meet the goals identified
229.11 in paragraph (a), clause (1), items (i), (ii), and (iii).

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

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

229.21 Sec. 59. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to
229.22 read:

229.23 Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
229.24 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
229.25 **CRISIS RESIDENTIAL SETTINGS.**

229.26 Subdivision 1. Exception for persons leaving institutions and crisis residential
229.27 settings. (a) By September 30, 2017, the commissioner shall establish an institutional and
229.28 crisis bed consumer-directed community supports budget exception process in the home
229.29 and community-based services waivers under Minnesota Statutes, sections 256B.092 and
229.30 256B.49. This budget exception process shall be available for any individual who:

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

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

230.3 (b) Institutional settings for purposes of this exception include intermediate care facilities
230.4 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
230.5 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
230.6 exception shall be limited to no more than the amount of appropriate services provided in
230.7 a noninstitutional setting as determined by the lead agency managing the individual's home
230.8 and community-based services waiver. The lead agency shall notify the Department of
230.9 Human Services of the budget exception.

230.10 Subd. 2. Shared services. (a) Medical assistance payments for shared services under
230.11 consumer-directed community supports are limited to this subdivision.

230.12 (b) For purposes of this subdivision, "shared services" means services provided at the
230.13 same time by the same direct care worker for individuals who have entered into an agreement
230.14 to share consumer-directed community support services.

230.15 (c) Shared services may include services in the personal assistance category as outlined
230.16 in the consumer-directed community supports community support plan and shared services
230.17 agreement, except:

230.18 (1) services for more than three individuals provided by one worker at one time;

230.19 (2) use of more than one worker for the shared services; and

230.20 (3) a child care program licensed under chapter 245A or operated by a local school
230.21 district or private school.

230.22 (d) The individuals or, as needed, their representatives shall develop the plan for shared
230.23 services when developing or amending the consumer-directed community supports plan,
230.24 and must follow the consumer-directed community supports process for approval of the
230.25 plan by the lead agency. The plan for shared services in an individual's consumer-directed
230.26 community supports plan shall include the intention to utilize shared services based on
230.27 individuals' needs and preferences.

230.28 (e) Individuals sharing services must use the same financial management services
230.29 provider.

230.30 (f) Individuals whose consumer-directed community supports community support plans
230.31 include the intention to utilize shared services must also jointly develop, with the support
230.32 of their representatives as needed, a shared services agreement. This agreement must include:

- 231.1 (1) the names of the individuals receiving shared services;
- 231.2 (2) the individuals' representative, if identified in their consumer-directed community
- 231.3 supports plans, and their duties;
- 231.4 (3) the names of the case managers;
- 231.5 (4) the financial management services provider;
- 231.6 (5) the shared services that must be provided;
- 231.7 (6) the schedule for shared services;
- 231.8 (7) the location where shared services must be provided;
- 231.9 (8) the training specific to each individual served;
- 231.10 (9) the training specific to providing shared services to the individuals identified in the
- 231.11 agreement;
- 231.12 (10) instructions to follow all required documentation for time and services provided;
- 231.13 (11) a contingency plan for each of the individuals that accounts for service provision
- 231.14 and billing in the absence of one of the individuals in a shared services setting due to illness
- 231.15 or other circumstances;
- 231.16 (12) signatures of all parties involved in the shared services; and
- 231.17 (13) agreement by each of the individuals who are sharing services on the number of
- 231.18 shared hours for services provided.
- 231.19 (g) Any individual or any individual's representative may withdraw from participating
- 231.20 in a shared services agreement at any time.
- 231.21 (h) The lead agency for each individual must authorize the use of the shared services
- 231.22 option based on the criteria that the shared service is appropriate to meet the needs, health,
- 231.23 and safety of each individual for whom they provide case management or care coordination.
- 231.24 (i) Nothing in this subdivision must be construed to reduce the total authorized
- 231.25 consumer-directed community supports budget for an individual.
- 231.26 (j) No later than September 30, 2019, the commissioner of human services shall:
- 231.27 (1) submit an amendment to the Centers for Medicare and Medicaid Services for the
- 231.28 home and community-based services waivers authorized under Minnesota Statutes, sections
- 231.29 256B.092 and 256B.49, to allow for a shared services option under consumer-directed
- 231.30 community supports; and

232.1 (2) with stakeholder input, develop guidance for shared services in consumer-directed
 232.2 community-supports within the Community Based Services Manual. Guidance must include:

232.3 (i) recommendations for negotiating payment for one-to-two and one-to-three services;
 232.4 and

232.5 (ii) a template of the shared services agreement.

232.6 **EFFECTIVE DATE.** This section is effective October 1, 2019, or upon federal approval,
 232.7 whichever is later, except for subdivision 2, paragraph (j), which is effective the day
 232.8 following final enactment. The commissioner of human services shall notify the revisor of
 232.9 statutes when federal approval is obtained.

232.10 Sec. 60. **DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE**
 232.11 **SYSTEM TRANSITION GRANTS.**

232.12 (a) The commissioner of human services shall establish annual grants to day training
 232.13 and habilitation providers that are projected to experience a funding gap upon the full
 232.14 implementation of Minnesota Statutes, section 256B.4914.

232.15 (b) In order to be eligible for a grant under this section, a day training and habilitation
 232.16 disability waiver provider must:

232.17 (1) serve at least 100 waiver service participants;

232.18 (2) be projected to receive a reduction in annual revenue from medical assistance for
 232.19 day services during the first year of full implementation of disability waiver rate system
 232.20 framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and
 232.21 at least \$300,000 compared to the annual medical assistance revenue for day services the
 232.22 provider received during the last full year during which banded rates under Minnesota
 232.23 Statutes, section 256B.4913, subdivision 4a, were effective; and

232.24 (3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

232.25 (c) A recipient of a grant under this section must develop a sustainability plan in
 232.26 partnership with the commissioner of human services. The sustainability plan must include:

232.27 (1) a review of all the provider's costs and an assessment of whether the provider is
 232.28 implementing available cost-control options appropriately;

232.29 (2) a review of all the provider's revenue and an assessment of whether the provider is
 232.30 leveraging available resources appropriately; and

233.1 (3) a practical strategy for closing the funding gap described in paragraph (b), clause
 233.2 (2).

233.3 (d) The commissioner of human services shall provide technical assistance and financial
 233.4 management advice to grant recipients as they develop and implement their sustainability
 233.5 plans.

233.6 (e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate
 233.7 to the commissioner of human services that it made a good faith effort to close the revenue
 233.8 gap described in paragraph (b), clause (2).

233.9 **Sec. 61. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
 233.10 **MNCHOICES 2.0.**

233.11 (a) The commissioner of human services must ensure that the MnCHOICES 2.0
 233.12 assessment and support planning tool incorporates a qualitative approach with open-ended
 233.13 questions and a conversational, culturally sensitive approach to interviewing that captures
 233.14 the assessor's professional judgment based on the person's responses.

233.15 (b) If the commissioner of human services convenes a working group or consults with
 233.16 stakeholders for the purposes of modifying the assessment and support planning process or
 233.17 tool, the commissioner must include members of the disability community, including
 233.18 representatives of organizations and individuals involved in assessment and support planning.

233.19 (c) Until MnCHOICES 2.0 is fully implemented, the commissioner shall permit counties
 233.20 to use the most recent legacy documents related to long-term service and supports
 233.21 assessments and shall reimburse counties in the same amount as the commissioner would
 233.22 were the county using the MnCHOICES assessment tool.

233.23 **Sec. 62. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 233.24 **PAYMENTS FOR COUNTY HUMAN SERVICES ACTIVITIES.**

233.25 By December 1, 2019, the commissioner of human services shall provide a report to the
 233.26 chairs and ranking minority members of the legislative committees with jurisdiction over
 233.27 human services finance and policy proposing a rate per assessment to be paid to counties
 233.28 and tribes for all medical assistance and county human services activities currently reimbursed
 233.29 via a random moment time study. The commissioner, in developing the proposal, shall use
 233.30 past estimates of time spent on each relevant activity. The commissioner's report shall
 233.31 include an explanation of how the commissioner determines the portion of capitated rates
 233.32 paid to health plans attributable to each type of activity also performed by a county or tribe.

234.1 The commissioner's proposal must include a single rate per activity for each activity for all
 234.2 populations, but may also include an alternative proposal for different rates per activity for
 234.3 each activity for different populations.

234.4 Sec. 63. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 234.5 **BARRIERS TO INDEPENDENT LIVING.**

234.6 By December 1, 2019, the commissioner of human services shall submit to the chairs
 234.7 and ranking minority members of the legislative committees with jurisdiction over human
 234.8 services finance and policy a report describing state and federal regulatory barriers, including
 234.9 provisions of the Fair Housing Act, that create barriers to independent living for persons
 234.10 with disabilities. In developing the report, the commissioner shall consult with stakeholders,
 234.11 including individuals with disabilities, advocacy organizations, and service providers.

234.12 Sec. 64. **ADULT FOSTER CARE MORATORIUM EXEMPTION.**

234.13 An adult foster care setting located in Elk River, Sherburne County, and licensed in
 234.14 2003 to serve four people is exempt from the moratorium under Minnesota Statutes, section
 234.15 245A.03, subdivision 7, until July 1, 2020.

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

234.17 Sec. 65. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER**
 234.18 **CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN**
 234.19 **COUNTY.**

234.20 (a) The commissioner of human services shall allow a housing with services establishment
 234.21 located in Minneapolis that provides customized living and 24-hour customized living
 234.22 services for clients enrolled in the brain injury (BI) or community access for disability
 234.23 inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer
 234.24 service capacity of up to 66 clients to no more than three new housing with services
 234.25 establishments located in Hennepin County.

234.26 (b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall
 234.27 determine that the new housing with services establishments described under paragraph (a)
 234.28 meet the BI and CADI waiver customized living and 24-hour customized living size
 234.29 limitation exception for clients receiving those services at the new housing with services
 234.30 establishments described under paragraph (a).

235.1 **Sec. 66. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 235.2 **PERSONAL CARE ASSISTANCE SERVICES COMPARABILITY WAIVER.**

235.3 The commissioner of human services shall submit by July 1, 2019, a waiver request to
 235.4 the Centers for Medicare and Medicaid Services to allow people receiving personal care
 235.5 assistance services as of December 31, 2019, to continue their eligibility for personal care
 235.6 assistance services under the personal care assistance service eligibility criteria in effect on
 235.7 December 31, 2019.

235.8 **Sec. 67. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 235.9 **TRANSITION PERIOD FOR MODIFIED ELIGIBILITY OF PERSONAL CARE**
 235.10 **ASSISTANCE.**

235.11 (a) Beginning at the latest date permissible under federal law, the modified eligibility
 235.12 criteria under Minnesota Statutes, section 256B.0625, subdivision 19a, and Minnesota
 235.13 Statutes, section 256B.0652, subdivision 6, paragraphs (b) and (d), shall apply on a rolling
 235.14 basis, at the time of annual assessments, to people receiving personal care assistance as of
 235.15 December 31, 2019.

235.16 (b) The commissioner shall establish a transition period for people receiving personal
 235.17 care assistance services as of December 31, 2019, who, at the time of the annual assessment
 235.18 described in paragraph (a), are determined to be ineligible for personal care assistance
 235.19 services. Service authorizations for this transition period shall not exceed one year.

235.20 **EFFECTIVE DATE.** This section is effective January 1, 2020, or upon federal approval,
 235.21 whichever is later. The commissioner shall notify the revisor of statutes when federal
 235.22 approval is obtained and when personal care assistance services provided under paragraph
 235.23 (b) have expired.

235.24 **Sec. 68. DIRECTION TO THE COMMISSIONER; REPORT ON ELIGIBILITY**
 235.25 **FOR PERSONAL CARE ASSISTANCE AND ACCESS TO DEVELOPMENTAL**
 235.26 **DISABILITIES AND COMMUNITY ACCESS FOR DISABILITY INCLUSION**
 235.27 **WAIVERS.**

235.28 By December 15, 2020, the commissioner shall submit a report to chairs and ranking
 235.29 minority members of the legislative committees with jurisdiction over human services on
 235.30 modifications to the eligibility criteria for the personal care assistance program and limits
 235.31 on the growth of the developmental disabilities and community access for disability inclusion
 235.32 waivers enacted following the 2019 legislative session. The report shall include the impact
 235.33 on people receiving or requesting services and any recommendations. By February 15, 2021,

236.1 the commissioner shall supplement the December 15, 2020, report with updated data and
236.2 information.

236.3 **Sec. 69. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
236.4 **INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL**
236.5 **DISABILITIES LEVEL OF CARE CRITERIA.**

236.6 By February 1, 2020, the commissioner of human services shall submit to the chairs and
236.7 ranking minority members of the legislative committees with jurisdiction over health and
236.8 human services finance and policy recommended language to codify in Minnesota Statutes
236.9 the commissioner's existing criteria for the determination of need for intermediate care
236.10 facility for persons with developmental disabilities level of care. The recommended language
236.11 shall include language clarifying "at risk of placement," "reasonable indication," and "might
236.12 require" as those expressions are used in Minnesota Statutes, section 256B.092, subdivision
236.13 7, paragraph (b). The recommended statutory language shall also include the commissioner's
236.14 current guidance with respect to the interpretation and application of the federal standard
236.15 under Code of Federal Regulations, title 42, section 483.440, that a person receiving the
236.16 services of an intermediate care facility for persons with developmental disabilities require
236.17 a continuous active treatment plan, including which characteristics are necessary or sufficient
236.18 for a determination of a need for active treatment. The commissioner shall submit the
236.19 recommended statutory language with a letter listing, with statutory references, all the
236.20 programs and services for which an intermediate care facility for persons with developmental
236.21 disabilities level of care is required.

236.22 **Sec. 70. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
236.23 **DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

236.24 The commissioner of human services, in consultation with stakeholders, shall evaluate
236.25 the feasibility of developing a rate methodology for the personal care assistance program
236.26 under Minnesota Statutes, section 256B.0659, and community first services and supports
236.27 under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system
236.28 under Minnesota Statutes, section 256B.4914, including determining the component values
236.29 and factors to include in such a rate methodology; consider aligning any rate methodology
236.30 with the collective bargaining agreement and negotiation cycle under Minnesota Statutes,
236.31 section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct
236.32 care workers; develop methods and determine the necessary resources for the commissioner
236.33 to more consistently collect and audit data from the direct care industry; and report
236.34 recommendations, including proposed draft legislation, to the chairs and ranking minority

237.1 members of the legislative committees with jurisdiction over human services policy and
237.2 finance by February 1, 2020.

237.3 **Sec. 71. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; HOME**
237.4 **CARE SERVICES PAYMENT REFORM PROPOSAL.**

237.5 The commissioner of human services shall submit to the chairs and ranking minority
237.6 members of the legislative committees with jurisdiction over human services finance and
237.7 policy a proposal to adopt a budget-neutral prospective payment system for nursing services
237.8 and home health services under Minnesota Statutes, sections 256B.0625, subdivision 6a,
237.9 and 256B.0653, and home care nursing services under Minnesota Statutes, sections
237.10 256B.0625, subdivision 7, and 256B.0624, modeled on the Medicare fee-for-service home
237.11 health prospective payment system. The commissioner shall include in the proposal a case
237.12 mix adjusted episodic rate, including services, therapies and supplies, minimum visits
237.13 required for an episodic rate, consolidated billing requirements, outlier payments,
237.14 low-utilization payments, and other criteria at the commissioner's discretion. In addition to
237.15 the budget-neutral payment reform proposal, the commissioner shall also submit a proposed
237.16 mechanism for updating the payment rates to reflect inflation in health care costs.

237.17 **Sec. 72. REVISOR INSTRUCTION.**

237.18 (a) The revisor of statutes shall change the term "developmental disability waiver" or
237.19 similar terms to "developmental disabilities waiver" or similar terms wherever they appear
237.20 in Minnesota Statutes. The revisor shall also make technical and other necessary changes
237.21 to sentence structure to preserve the meaning of the text.

237.22 (b) The revisor of statutes, in consultation with the House Research Department, Office
237.23 of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall
237.24 prepare legislation for the 2020 legislative session to codify existing session laws governing
237.25 consumer-directed community supports in Minnesota Statutes, chapter 256B.

237.26 **Sec. 73. REPEALER.**

237.27 Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.

ARTICLE 6

DIRECT CARE AND TREATMENT

238.1
238.2
238.3 Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision
238.4 to read:

238.5 Subd. 3. Administrative review of county liability for cost of care. (a) The county of
238.6 financial responsibility may submit a written request for administrative review by the
238.7 commissioner of the county's payment of the cost of care when a delay in discharge of a
238.8 client from a regional treatment center, state-operated community-based behavioral health
238.9 hospital, or other state-operated facility results from the following actions by the facility:

238.10 (1) the facility did not provide notice to the county that the facility has determined that
238.11 it is clinically appropriate for a client to be discharged;

238.12 (2) the notice to the county that the facility has determined that it is clinically appropriate
238.13 for a client to be discharged was communicated on a holiday or weekend;

238.14 (3) the required documentation or procedures for discharge were not completed in order
238.15 for the discharge to occur in a timely manner; or

238.16 (4) the facility disagrees with the county's discharge plan.

238.17 (b) The county of financial responsibility may not appeal the determination that it is
238.18 clinically appropriate for a client to be discharged from a regional treatment center,
238.19 state-operated community-based behavioral health hospital, or other state-operated facility.

238.20 (c) The commissioner must evaluate the request for administrative review and determine
238.21 if the facility's actions listed in paragraph (a) caused undue delay in discharging the client.
238.22 If the commissioner determines that the facility's actions listed in paragraph (a) caused
238.23 undue delay in discharging the client, the county's liability will be reduced to the level of
238.24 the cost of care for a client whose stay in a facility is determined to be clinically appropriate,
238.25 effective on the date of the facility's action or failure to act that caused the delay. The
238.26 commissioner's determination under this subdivision is final.

238.27 (d) If a county's liability is reduced pursuant to paragraph (c), a county's liability will
238.28 return to the level of the cost of care for a client whose stay in a facility is determined to no
238.29 longer be appropriate effective on the date the facility rectifies the action or failure to act
238.30 that caused the delay under paragraph (a).

238.31 (e) Any difference in the county cost of care liability resulting from administrative review
238.32 under this subdivision shall not be billed to the client or applied to future reimbursement
238.33 from the client's estate or relatives.

239.1 Sec. 2. **DIRECTION TO COMMISSIONER; REPORT REQUIRED; DISCHARGE**
 239.2 **DELAY REDUCTION.**

239.3 No later than January 1, 2023, the commissioner of human services must submit a report
 239.4 to the chairs and ranking minority members of the legislative committees with jurisdiction
 239.5 over human services that provides an update on county and state efforts to reduce the number
 239.6 of days clients spend in state-operated facilities after discharge from the facility has been
 239.7 determined to be clinically appropriate. The report must also include information on the
 239.8 fiscal impact of clinically inappropriate stays in these facilities.

239.9 Sec. 3. **DIRECTION TO COMMISSIONER; MSOCS COON RAPIDS ILEX**
 239.10 **CLOSURE.**

239.11 The commissioner of human services shall close the Minnesota state-operated community
 239.12 services program known as MSOCS Coon Rapids Ilex. The commissioner must not reopen
 239.13 or redesign the program. For the purposes of this section:

239.14 (1) a program is considered closed if the commissioner discontinues providing services
 239.15 at a given location;

239.16 (2) a program is considered reopened if the commissioner opens a new program or begins
 239.17 providing a new service at a location that was previously closed; and

239.18 (3) a program is considered redesigned if the commissioner does not change the nature
 239.19 of the services provided, but does change the focus of the population served by the program.

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

239.21 Sec. 4. **REPEALER.**

239.22 Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

239.23 **ARTICLE 7**

239.24 **OPERATIONS**

239.25 Section 1. Minnesota Statutes 2018, section 16A.055, subdivision 1a, is amended to read:

239.26 Subd. 1a. **Additional duties.** The commissioner may assist state agencies by providing
 239.27 analytical, statistical, program evaluation using experimental or quasi-experimental design,
 239.28 and organizational development services to state agencies in order to assist the agency to
 239.29 achieve the agency's mission and to operate efficiently and effectively. For purposes of this
 239.30 section, "experimental design" means a method of evaluating the impact of a service that

240.1 uses random assignment to assign participants into groups that respectively receive the
 240.2 studied service and those that receive service as usual, so that any difference in outcomes
 240.3 found at the end of the evaluation can be attributed to the studied service; and
 240.4 "quasi-experimental design" means a method of evaluating the impact of a service that uses
 240.5 strategies other than random assignment to establish statistically similar groups that
 240.6 respectively receive the service and those that receive service as usual, so that any difference
 240.7 in outcomes found at the end of the evaluation can be attributed to the studied service.

240.8 Sec. 2. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

240.9 Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that
 240.10 the program complies with all applicable rules and laws, the commissioner shall issue a
 240.11 license consistent with this section or, if applicable, a temporary change of ownership license
 240.12 under section 245A.043. At minimum, the license shall state:

240.13 (1) the name of the license holder;

240.14 (2) the address of the program;

240.15 (3) the effective date and expiration date of the license;

240.16 (4) the type of license;

240.17 (5) the maximum number and ages of persons that may receive services from the program;

240.18 and

240.19 (6) any special conditions of licensure.

240.20 (b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years
 240.21 if:

240.22 (1) the commissioner is unable to conduct the evaluation or observation required by
 240.23 subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

240.24 (2) certain records and documents are not available because persons are not yet receiving
 240.25 services from the program; and

240.26 (3) the applicant complies with applicable laws and rules in all other respects.

240.27 (c) A decision by the commissioner to issue a license does not guarantee that any person
 240.28 or persons will be placed or cared for in the licensed program. ~~A license shall not be~~
 240.29 ~~transferable to another individual, corporation, partnership, voluntary association, other~~
 240.30 ~~organization, or controlling individual or to another location.~~

241.1 ~~(d) A license holder must notify the commissioner and obtain the commissioner's approval~~
 241.2 ~~before making any changes that would alter the license information listed under paragraph~~
 241.3 ~~(a).~~

241.4 ~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not
 241.5 issue or reissue a license if the applicant, license holder, or controlling individual has:

241.6 (1) been disqualified and the disqualification was not set aside and no variance has been
 241.7 granted;

241.8 (2) been denied a license within the past two years;

241.9 (3) had a license issued under this chapter revoked within the past five years;

241.10 (4) an outstanding debt related to a license fee, licensing fine, or settlement agreement
 241.11 for which payment is delinquent; or

241.12 (5) failed to submit the information required of an applicant under subdivision 1,
 241.13 paragraph (f) or (g), after being requested by the commissioner.

241.14 When a license issued under this chapter is revoked under clause (1) or (3), the license
 241.15 holder and controlling individual may not hold any license under chapter 245A or 245D for
 241.16 five years following the revocation, and other licenses held by the applicant, license holder,
 241.17 or controlling individual shall also be revoked.

241.18 ~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an
 241.19 individual living in the household where the licensed services will be provided as specified
 241.20 under section 245C.03, subdivision 1, has been disqualified and the disqualification has not
 241.21 been set aside and no variance has been granted.

241.22 ~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued
 241.23 under this chapter has been suspended or revoked and the suspension or revocation is under
 241.24 appeal, the program may continue to operate pending a final order from the commissioner.
 241.25 If the license under suspension or revocation will expire before a final order is issued, a
 241.26 temporary provisional license may be issued provided any applicable license fee is paid
 241.27 before the temporary provisional license is issued.

241.28 ~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the
 241.29 disqualification of a controlling individual or license holder, and the controlling individual
 241.30 or license holder is ordered under section 245C.17 to be immediately removed from direct
 241.31 contact with persons receiving services or is ordered to be under continuous, direct
 241.32 supervision when providing direct contact services, the program may continue to operate
 241.33 only if the program complies with the order and submits documentation demonstrating

242.1 compliance with the order. If the disqualified individual fails to submit a timely request for
 242.2 reconsideration, or if the disqualification is not set aside and no variance is granted, the
 242.3 order to immediately remove the individual from direct contact or to be under continuous,
 242.4 direct supervision remains in effect pending the outcome of a hearing and final order from
 242.5 the commissioner.

242.6 ~~(h)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care
 242.7 Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A,
 242.8 part 226, relocation within the same county by a licensed family day care provider, shall
 242.9 be considered an extension of the license for a period of no more than 30 calendar days or
 242.10 until the new license is issued, whichever occurs first, provided the county agency has
 242.11 determined the family day care provider meets licensure requirements at the new location.

242.12 ~~(i)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire
 242.13 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must
 242.14 apply for and be granted a new license to operate the program or the program must not be
 242.15 operated after the expiration date.

242.16 ~~(j)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has
 242.17 been determined that a tribal licensing authority has established jurisdiction to license the
 242.18 program or service.

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

242.20 Sec. 3. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to
 242.21 read:

242.22 **Subd. 7a. Notification required.** (a) A license holder must notify the commissioner and
 242.23 obtain the commissioner's approval before making any change that would alter the license
 242.24 information listed under subdivision 7, paragraph (a).

242.25 (b) At least 30 days before the effective date of a change, the license holder must notify
 242.26 the commissioner in writing of any change:

242.27 (1) to the license holder's controlling individual as defined in section 245A.02, subdivision
 242.28 5a;

242.29 (2) to license holder information on file with the secretary of state;

242.30 (3) in the location of the program or service licensed under this chapter; and

242.31 (4) in the federal or state tax identification number associated with the license holder.

243.1 (c) When a license holder notifies the commissioner of a change to the business structure
 243.2 governing the licensed program or services but is not selling the business, the license holder
 243.3 must provide amended articles of incorporation and other documentation of the change and
 243.4 any other information requested by the commissioner.

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

243.6 Sec. 4. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

243.7 Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid
 243.8 for a premises and individual, organization, or government entity identified by the
 243.9 commissioner on the license. A license is not transferable or assignable.

243.10 Subd. 2. **Change of ownership.** If the commissioner determines that there will be a
 243.11 change of ownership, the commissioner shall require submission of a new license application.

243.12 A change of ownership occurs when:

243.13 (1) the license holder sells or transfers 100 percent of the property, stock, or assets;

243.14 (2) the license holder merges with another organization;

243.15 (3) the license holder consolidates with two or more organizations, resulting in the
 243.16 creation of a new organization;

243.17 (4) there is a change in the federal tax identification number associated with the license
 243.18 holder; or

243.19 (5) there is a turnover of each controlling individual associated with the license within
 243.20 a 12-month period. A change to the license holder's controlling individuals, including a
 243.21 change due to a transfer of stock, is not a change of ownership if at least one controlling
 243.22 individual who was listed on the license for at least 12 consecutive months continues to be
 243.23 a controlling individual after the reported change.

243.24 Subd. 3. **Change of ownership requirements.** (a) A license holder who intends to
 243.25 change the ownership of the program or service under subdivision 2 to a party that intends
 243.26 to assume operation without an interruption in service longer than 60 days after acquiring
 243.27 the program or service must provide the commissioner with written notice of the proposed
 243.28 sale or change, on a form provided by the commissioner, at least 60 days before the
 243.29 anticipated date of the change in ownership. For purposes of this subdivision and subdivision
 243.30 4, "party" means the party that intends to operate the service or program.

243.31 (b) The party must submit a license application under this chapter on the form and in
 243.32 the manner prescribed by the commissioner at least 30 days before the change of ownership

244.1 is complete and must include documentation to support the upcoming change. The form
244.2 and manner of the application prescribed by the commissioner shall require only information
244.3 which is specifically required by statute or rule. The party must comply with background
244.4 study requirements under chapter 245C and shall pay the application fee required in section
244.5 245A.10. A party that intends to assume operation without an interruption in service longer
244.6 than 60 days after acquiring the program or service is exempt from the requirements of
244.7 Minnesota Rules, part 9530.6800.

244.8 (c) The commissioner may develop streamlined application procedures when the party
244.9 is an existing license holder under this chapter and is acquiring a program licensed under
244.10 this chapter or service in the same service class as one or more licensed programs or services
244.11 the party operates and those licenses are in substantial compliance according to the licensing
244.12 standards in this chapter and applicable rules. For purposes of this subdivision, "substantial
244.13 compliance" means within the past 12 months the commissioner did not: (i) issue a sanction
244.14 under section 245A.07 against a license held by the party or (ii) make a license held by the
244.15 party conditional according to section 245A.06.

244.16 (d) Except when a temporary change of ownership license is issued pursuant to
244.17 subdivision 4, the existing license holder is solely responsible for operating the program
244.18 according to applicable rules and statutes until a license under this chapter is issued to the
244.19 party.

244.20 (e) If a licensing inspection of the program or service was conducted within the previous
244.21 12 months and the existing license holder's license record demonstrates substantial
244.22 compliance with the applicable licensing requirements, the commissioner may waive the
244.23 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
244.24 commissioner proof that the premises was inspected by a fire marshal or that the fire marshal
244.25 deemed that an inspection was not warranted and proof that the premises was inspected for
244.26 compliance with the building code or that no inspection was deemed warranted.

244.27 (f) If the party is seeking a license for a program or service that has an outstanding
244.28 correction order, the party must submit a letter with the license application identifying how
244.29 and within what length of time the party shall resolve the outstanding correction order and
244.30 come into full compliance with the licensing requirements.

244.31 (g) Any action taken under section 245A.06 or 245A.07 against the existing license
244.32 holder's license at the time the party is applying for a license, including when the existing
244.33 license holder is operating under a conditional license or is subject to a revocation, shall

245.1 remain in effect until the commissioner determines that the grounds for the action are
245.2 corrected or no longer exist.

245.3 (h) The commissioner shall evaluate the application of the party according to section
245.4 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner
245.5 determines that the party complies with applicable laws and rules, the commissioner may
245.6 issue a license or a temporary change of ownership license.

245.7 (i) The commissioner may deny an application as provided in section 245A.05. An
245.8 applicant whose application was denied by the commissioner may appeal the denial according
245.9 to section 245A.05.

245.10 (j) This subdivision does not apply to a licensed program or service located in a home
245.11 where the license holder resides.

245.12 Subd. 4. **Temporary change of ownership license.** (a) After receiving the party's
245.13 application and upon the written request of the existing license holder and the party, the
245.14 commissioner may issue a temporary change of ownership license to the party while the
245.15 commissioner evaluates the party's application. Until a decision is made to grant or deny a
245.16 license under this chapter, the existing license holder and the party shall both be responsible
245.17 for operating the program or service according to applicable laws and rules, and the sale or
245.18 transfer of the license holder's ownership interest in the licensed program or service does
245.19 not terminate the existing license.

245.20 (b) The commissioner may establish criteria to issue a temporary change of ownership
245.21 license, if a license holder's death, divorce, or other event affects the ownership of the
245.22 program, when an applicant seeks to assume operation of the program or service to ensure
245.23 continuity of the program or service while a license application is evaluated. This subdivision
245.24 applies to any program or service licensed under this chapter.

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

245.26 Sec. 5. Minnesota Statutes 2018, section 245A.065, is amended to read:

245.27 **245A.065 CHILD CARE FIX-IT TICKET.**

245.28 Subdivision 1. **Contents of fix-it tickets.** (a) In lieu of a correction order under section
245.29 245A.06, the commissioner ~~shall~~ may issue a fix-it ticket to a family child care or child care
245.30 center license holder if the commissioner finds that:

246.1 (1) the license holder has failed to comply with a requirement in this chapter or Minnesota
 246.2 Rules, chapter 9502 or 9503, ~~that the commissioner determines to be eligible for a fix-it~~
 246.3 ~~ticket;~~

246.4 (2) the violation does not imminently endanger the health, safety, or rights of the persons
 246.5 served by the program;

246.6 (3) the license holder did not receive a fix-it ticket or correction order for the violation
 246.7 at the license holder's last licensing inspection; and

246.8 (4) the violation ~~can~~ cannot be corrected at the time of inspection ~~or within 48 hours,~~
 246.9 ~~excluding Saturdays, Sundays, and holidays;~~ and

246.10 ~~(5) the license holder corrects the violation at the time of inspection or agrees to correct~~
 246.11 ~~the violation within 48 hours, excluding Saturdays, Sundays, and holidays.~~

246.12 (b) The commissioner shall not issue a fix-it ticket for violations that are corrected at
 246.13 the time of the inspection.

246.14 (c) The fix-it ticket must state:

246.15 (1) the conditions that constitute a violation of the law or rule;

246.16 (2) the specific law or rule violated; and

246.17 (3) that the violation ~~was corrected at the time of inspection or~~ must be corrected within
 246.18 48 hours, excluding Saturdays, Sundays, and holidays.

246.19 ~~(e)~~ (d) The commissioner shall not publicly publish a fix-it ticket on the department's
 246.20 website.

246.21 ~~(d)~~ (e) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it
 246.22 ticket, the license holder must correct the violation and within one week submit evidence
 246.23 to the licensing agency that the violation was corrected.

246.24 ~~(e)~~ (f) If the violation is not corrected ~~at the time of inspection or~~ within 48 hours,
 246.25 excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to
 246.26 establish that the license holder corrected the violation, the commissioner must issue a
 246.27 correction order, according to section 245A.06, for the violation of Minnesota law or rule
 246.28 identified in the fix-it ticket ~~according to section 245A.06.~~

246.29 ~~(f) The commissioner shall, following consultation with family child care license holders,~~
 246.30 ~~child care center license holders, and county agencies, issue a report by October 1, 2017,~~
 246.31 ~~that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503,~~
 246.32 ~~that are eligible for a fix-it ticket. The commissioner shall provide the report to county~~

247.1 ~~agencies and the chairs and ranking minority members of the legislative committees with~~
 247.2 ~~jurisdiction over child care, and shall post the report to the department's website.~~

247.3 Subd. 2. **Fix-it ticket laws and rules.** (a) For family child care license holders, violations
 247.4 of the following laws and rules may qualify only for a fix-it ticket: 9502.0335, subpart 10;
 247.5 9502.0375, subpart 2; 9502.0395; 9502.0405, subpart 3; 9502.0405, subpart 4, item A;
 247.6 9502.0415, subpart 3; 9502.0425, subpart 2 (outdoor play spaces must be free from litter,
 247.7 rubbish, unlocked vehicles, or human or animal waste); 9502.0425, subpart 3 (wading pools
 247.8 must be kept clean); 9502.0425, subpart 5; 9502.0425, subpart 7, item F (screens on exterior
 247.9 doors and windows when biting insects are prevalent); 9502.0425, subpart 8; 9502.0425,
 247.10 subpart 10; 9502.0425, subpart 11 (decks free of splinters); 9502.0425, subpart 13 (toilets
 247.11 flush thoroughly); 9502.0425, subpart 16; 9502.0435, subpart 1; 9502.0435, subpart 3;
 247.12 9502.0435, subpart 7; 9502.0435, subpart 8, item B; 9502.0435, subpart 8, item E; 9502.0435,
 247.13 subpart 12, items A through E; 9502.0435, subpart 13; 9502.0435, subpart 14; 9502.0435,
 247.14 subpart 15; 9502.0435, subpart 15, items A and B; 9502.0445, subpart 1, item B; 9502.0445,
 247.15 subpart 3, items B through D; 9502.0445, subpart 4, items A through C; 245A.04, subdivision
 247.16 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.146, subdivision
 247.17 3, paragraph (c); 245A.148; 245A.152; 245A.50, subdivision 7; 245A.51, subdivision 3,
 247.18 paragraph (d) (emergency preparedness plan available for review and posted in prominent
 247.19 location).

247.20 (b) For child care center license holders, violations of the following laws and rules may
 247.21 qualify only for a fix-it ticket: 9503.0120, item B; 9503.0120, item E; 9503.0125, item E;
 247.22 9503.0125, item F; 9503.0125, item I; 9503.0125, item M; 9503.0140, subpart 2; 9503.0140,
 247.23 subpart 7, item D; 9503.0140, subpart 9; 9503.0140, subpart 10; 9503.0140, subpart 13;
 247.24 9503.0140, subpart 14; 9503.0140, subpart 15; 9503.0140, subpart 16 (item missing from
 247.25 first-aid kit); 9503.0140, subpart 18; 9503.0140, subpart 19; 9503.0140, subpart 20;
 247.26 9503.0140, subpart 21 (emergency plan not posted in prominent place); 9503.0145, subpart
 247.27 2; 9503.0145, subpart 3; 9503.0145, subpart 4, item D; 9503.0145, subpart 8 (drinking water
 247.28 provided in single service cups or at an accessible drinking fountain); 9503.0155, subpart
 247.29 7, item D; 9503.0155, subpart 13; 9503.0155, subpart 16; 9503.0155, subpart 17; 9503.0155,
 247.30 subpart 18, item D; 9503.0170, subpart 3; 9503.0145, subpart 7, item D; 245A.04, subdivision
 247.31 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.14, subdivision
 247.32 8, paragraph (b) (experienced aide identification posting); 245A.146, subdivision 3, paragraph
 247.33 (c); 245A.152; 245A.41, subdivision 3, paragraph (d); 245A.41, subdivision 3, paragraph
 247.34 (e); 245A.41, subdivision 3, paragraph (f).

248.1 Sec. 6. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to
248.2 read:

248.3 Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment
248.4 field" means a program exclusively serving individuals 18 years of age and older and that
248.5 is required to be:

248.6 (1) licensed under chapter 245G; or

248.7 (2) registered under section 157.17 as a board and lodge establishment that predominantly
248.8 serves individuals being treated for or recovering from a substance use disorder.

248.9 Sec. 7. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

248.10 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification
248.11 if the commissioner finds that the individual has submitted sufficient information to
248.12 demonstrate that the individual does not pose a risk of harm to any person served by the
248.13 applicant, license holder, or other entities as provided in this chapter.

248.14 (b) In determining whether the individual has met the burden of proof by demonstrating
248.15 the individual does not pose a risk of harm, the commissioner shall consider:

248.16 (1) the nature, severity, and consequences of the event or events that led to the
248.17 disqualification;

248.18 (2) whether there is more than one disqualifying event;

248.19 (3) the age and vulnerability of the victim at the time of the event;

248.20 (4) the harm suffered by the victim;

248.21 (5) vulnerability of persons served by the program;

248.22 (6) the similarity between the victim and persons served by the program;

248.23 (7) the time elapsed without a repeat of the same or similar event;

248.24 (8) documentation of successful completion by the individual studied of training or
248.25 rehabilitation pertinent to the event; and

248.26 (9) any other information relevant to reconsideration.

248.27 (c) If the individual requested reconsideration on the basis that the information relied
248.28 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines
248.29 that the information relied upon to disqualify the individual is correct, the commissioner

249.1 must also determine if the individual poses a risk of harm to persons receiving services in
249.2 accordance with paragraph (b).

249.3 (d) For an individual seeking employment in the substance use disorder treatment field,
249.4 the commissioner shall set aside the disqualification if the following criteria are met:

249.5 (1) the individual is not disqualified for a crime of violence as listed under section
249.6 624.712, subdivision 5, except that the following crimes are prohibitory offenses: crimes
249.7 listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023,
249.8 subdivision 2; 152.024; or 152.025;

249.9 (2) the individual is not disqualified under section 245C.15, subdivision 1;

249.10 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph
249.11 (b);

249.12 (4) the individual provided documentation of successful completion of treatment, at least
249.13 one year prior to the date of the request for reconsideration, at a program licensed under
249.14 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after
249.15 the successful completion of treatment;

249.16 (5) the individual provided documentation demonstrating abstinence from controlled
249.17 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to
249.18 the date of the request for reconsideration; and

249.19 (6) the individual is seeking employment in the substance use disorder treatment field.

249.20 Sec. 8. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

249.21 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under
249.22 this section, the disqualified individual remains disqualified, but may hold a license and
249.23 have direct contact with or access to persons receiving services. Except as provided in
249.24 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the
249.25 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.
249.26 For personal care provider organizations, the commissioner's set-aside may further be limited
249.27 to a specific individual who is receiving services. For new background studies required
249.28 under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was
249.29 previously set aside for the license holder's program and the new background study results
249.30 in no new information that indicates the individual may pose a risk of harm to persons
249.31 receiving services from the license holder, the previous set-aside shall remain in effect.

250.1 (b) If the commissioner has previously set aside an individual's disqualification for one
 250.2 or more programs or agencies, and the individual is the subject of a subsequent background
 250.3 study for a different program or agency, the commissioner shall determine whether the
 250.4 disqualification is set aside for the program or agency that initiated the subsequent
 250.5 background study. A notice of a set-aside under paragraph (c) shall be issued within 15
 250.6 working days if all of the following criteria are met:

250.7 (1) the subsequent background study was initiated in connection with a program licensed
 250.8 or regulated under the same provisions of law and rule for at least one program for which
 250.9 the individual's disqualification was previously set aside by the commissioner;

250.10 (2) the individual is not disqualified for an offense specified in section 245C.15,
 250.11 subdivision 1 or 2;

250.12 (3) the commissioner has received no new information to indicate that the individual
 250.13 may pose a risk of harm to any person served by the program; and

250.14 (4) the previous set-aside was not limited to a specific person receiving services.

250.15 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the
 250.16 substance use disorder field, if the commissioner has previously set aside an individual's
 250.17 disqualification for one or more programs or agencies in the substance use disorder treatment
 250.18 field, and the individual is the subject of a subsequent background study for a different
 250.19 program or agency in the substance use disorder treatment field, the commissioner shall set
 250.20 aside the disqualification for the program or agency in the substance use disorder treatment
 250.21 field that initiated the subsequent background study when the criteria under paragraph (b),
 250.22 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified
 250.23 in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued
 250.24 within 15 working days.

250.25 ~~(e)~~(d) When a disqualification is set aside under paragraph (b), the notice of background
 250.26 study results issued under section 245C.17, in addition to the requirements under section
 250.27 245C.17, shall state that the disqualification is set aside for the program or agency that
 250.28 initiated the subsequent background study. The notice must inform the individual that the
 250.29 individual may request reconsideration of the disqualification under section 245C.21 on the
 250.30 basis that the information used to disqualify the individual is incorrect.

250.31 Sec. 9. [245L.01] OFFICE OF INSPECTOR GENERAL.

250.32 Subdivision 1. Creation. A state Office of Inspector General is created.

251.1 Subd. 2. **Director.** (a) The office shall be under the direction of an inspector general
251.2 who shall be appointed by the governor, with the advice and consent of the senate, for a
251.3 term ending on June 30 of the sixth calendar year after appointment. Senate confirmation
251.4 of the inspector general shall be as provided by section 15.066. The inspector general shall
251.5 appoint deputies to serve in the office as necessary to fulfill the duties of the office. The
251.6 inspector general may delegate to a subordinate employee the exercise of a specified statutory
251.7 power or duty, subject to the control of the inspector general. Every delegation must be by
251.8 written order filed with the secretary of state.

251.9 (b) The inspector general shall be in the unclassified service, but may be removed only
251.10 for cause.

251.11 Subd. 3. **Duties.** The inspector general shall, in coordination with counties where
251.12 applicable:

251.13 (1) develop and maintain the licensing and regulatory functions related to hospitals,
251.14 boarding care homes, outpatient surgical centers, birthing centers, nursing homes, home
251.15 care agencies, supplemental nursing services agencies, hospice providers, housing with
251.16 services establishments, assisted living facilities, prescribed pediatric extended care centers,
251.17 and board and lodging establishments with special services consistent with chapters 144A,
251.18 144D, 144G, and 144H, and sections 144.50 to 144.58, 144.615, and 157.17;

251.19 (2) notwithstanding the requirement under section 144A.52, subdivision 1, that the
251.20 director of the Office of Health Facility Complaints be appointed by the commissioner of
251.21 health, assume the role of director of the Office of Health Facility Complaints;

251.22 (3) develop and maintain the licensing and regulatory functions related to adult day care,
251.23 child care and early education, children's residential facilities, foster care, home and
251.24 community-based services, independent living assistance for youth, outpatient mental health
251.25 clinics or centers, residential mental health treatment for adults, and substance use disorder
251.26 treatment consistent with chapters 245, 245A, 245D, 245F, 245G, 245H, 252, and 256;

251.27 (4) conduct background studies according to sections 144.057, 144A.476, 144A.62,
251.28 144A.754, and 157.17 and chapter 245C. For the purpose of completing background studies,
251.29 the inspector general shall have authority to access maltreatment data maintained by local
251.30 welfare agencies or agencies responsible for assessing or investigating reports under section
251.31 626.556, and names of substantiated perpetrators related to maltreatment of vulnerable
251.32 adults maintained by the commissioner of human services under section 626.557;

251.33 (5) develop and maintain the background study requirements consistent with chapter
251.34 245C;

252.1 (6) be responsible for ensuring the detection, prevention, investigation, and resolution
252.2 of fraudulent activities or behavior by applicants, recipients, providers, and other participants
252.3 in the human services programs administered by the Department of Human Services;

252.4 (7) require county agencies to identify overpayments, establish claims, and utilize all
252.5 available and cost-beneficial methodologies to collect and recover these overpayments in
252.6 the human services programs administered by the Department of Human Services; and

252.7 (8) develop, maintain, and administer the common entry point established on July 1,
252.8 2015, under section 626.557, subdivision 9.

252.9 **EFFECTIVE DATE.** This section is effective July 1, 2020.

252.10 Sec. 10. **[2451.02] TRANSFER OF DUTIES.**

252.11 Subdivision 1. **Transfer and reorganization orders.** (a) Section 15.039 applies to the
252.12 transfer of duties required by this chapter.

252.13 (b) For an employee affected by the transfer of duties required by this chapter, the
252.14 seniority accrued by the employee at the employee's former agency transfers to the employee's
252.15 new agency.

252.16 Subd. 2. **Transfer of duties from the commissioner of human services.** The
252.17 commissioner of administration, with approval of the governor, may issue reorganization
252.18 orders under section 16B.37 as necessary to carry out the transfer of duties of the
252.19 commissioner of human services required by this chapter. The provision of section 16B.37,
252.20 subdivision 1, stating that transfers under that section may be made only to an agency that
252.21 has been in existence for at least one year does not apply to transfers to an agency created
252.22 by this chapter.

252.23 Subd. 3. **Transfer of duties from the commissioner of health.** The commissioner of
252.24 administration, with approval of the governor, may issue reorganization orders under section
252.25 16B.37 as necessary to carry out the transfer of duties of the commissioner of health required
252.26 by this chapter. The provision of section 16B.37, subdivision 1, stating that transfers under
252.27 that section may be made only to an agency that has been in existence for at least one year
252.28 does not apply to transfers to an agency created by this chapter.

252.29 Subd. 4. **Aggregate cost limit.** The commissioner of management and budget must
252.30 ensure that the aggregate cost for the inspector general of the Office of Inspector General
252.31 is not more than the aggregate cost of the primary executives in the Office of Inspector
252.32 General at the Department of Human Services and the Health Regulation Division at the
252.33 Department of Health immediately before the effective date of subdivision 2.

253.1 **EFFECTIVE DATE.** Subdivisions 1, 2, and 4, are effective July 1, 2020. Subdivision
 253.2 3 is effective July 1, 2022.

253.3 Sec. 11. **[256.0113] COUNTY HUMAN SERVICES STATE FUNDING**

253.4 **REALLOCATION.**

253.5 (a) Beginning October 1, 2019, counties and tribes or tribal agencies receiving human
 253.6 services grants funded exclusively with state general fund dollars may allocate any
 253.7 unexpended grant amounts to any county or tribal human services activity for the fourth
 253.8 quarter of the county or tribe's fiscal year.

253.9 (b) Any proposed reallocation of unspent funds must be approved by majority vote of
 253.10 the county board or the tribe or tribal agency's governing body.

253.11 (c) Each county, tribe, or tribal agency shall report any approved reallocation of unspent
 253.12 grant funds to the commissioner of human services by March 31 of each year following a
 253.13 reallocation under this section. The report shall describe the use of the reallocated human
 253.14 services grant funds, compare how the funds were allocated prior to the reallocation, and
 253.15 explain the advantages or disadvantages of the reallocation.

253.16 Sec. 12. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

253.17 Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare
 253.18 and Medicaid Services determines that a provider is designated "high-risk," the commissioner
 253.19 may withhold payment from providers within that category upon initial enrollment for a
 253.20 90-day period. The withholding for each provider must begin on the date of the first
 253.21 submission of a claim.

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

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

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

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

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

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

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

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

254.11 (c) The commissioner may revoke the enrollment of an ordering or rendering provider
254.12 for a period of not more than one year, if the provider fails to maintain and, upon request
254.13 from the commissioner, provide access to documentation relating to written orders or requests
254.14 for payment for durable medical equipment, certifications for home health services, or
254.15 referrals for other items or services written or ordered by such provider, when the
254.16 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
254.17 to maintain documentation or provide access to documentation on more than one occasion.
254.18 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
254.19 under the provisions of section 256B.064.

254.20 (d) The commissioner shall terminate or deny the enrollment of any individual or entity
254.21 if the individual or entity has been terminated from participation in Medicare or under the
254.22 Medicaid program or Children's Health Insurance Program of any other state. The
254.23 commissioner may exempt a rehabilitation agency from termination or denial that would
254.24 otherwise be required under this paragraph, if the agency:

254.25 (1) is unable to retain Medicare certification and enrollment solely due to a lack of billing
254.26 to the Medicare program;

254.27 (2) meets all other applicable Medicare certification requirements based on an on-site
254.28 review completed by the commissioner of health; and

254.29 (3) serves primarily a pediatric population.

254.30 (e) As a condition of enrollment in medical assistance, the commissioner shall require
254.31 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
254.32 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
254.33 Services, its agents, or its designated contractors and the state agency, its agents, or its

255.1 designated contractors to conduct unannounced on-site inspections of any provider location.
255.2 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
255.3 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
255.4 and standards used to designate Medicare providers in Code of Federal Regulations, title
255.5 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
255.6 The commissioner's designations are not subject to administrative appeal.

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

255.13 (g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
255.14 medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers
255.15 meeting the durable medical equipment provider and supplier definition in clause (3),
255.16 operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is
255.17 annually renewed and designates the Minnesota Department of Human Services as the
255.18 obligee, and must be submitted in a form approved by the commissioner. For purposes of
255.19 this clause, the following medical suppliers are not required to obtain a surety bond: a
255.20 federally qualified health center, a home health agency, the Indian Health Service, a
255.21 pharmacy, and a rural health clinic.

255.22 (2) At the time of initial enrollment or reenrollment, durable medical equipment providers
255.23 and suppliers defined in clause (3) must purchase a surety bond of \$50,000. If a revalidating
255.24 provider's Medicaid revenue in the previous calendar year is up to and including \$300,000,
255.25 the provider agency must purchase a surety bond of \$50,000. If a revalidating provider's
255.26 Medicaid revenue in the previous calendar year is over \$300,000, the provider agency must
255.27 purchase a surety bond of \$100,000. The surety bond must allow for recovery of costs and
255.28 fees in pursuing a claim on the bond.

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

255.33 (h) The Department of Human Services may require a provider to purchase a surety
255.34 bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment

256.1 if: (1) the provider fails to demonstrate financial viability, (2) the department determines
256.2 there is significant evidence of or potential for fraud and abuse by the provider, or (3) the
256.3 provider or category of providers is designated high-risk pursuant to paragraph (a) and as
256.4 per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an
256.5 amount of \$100,000 or ten percent of the provider's payments from Medicaid during the
256.6 immediately preceding 12 months, whichever is greater. The surety bond must name the
256.7 Department of Human Services as an obligee and must allow for recovery of costs and fees
256.8 in pursuing a claim on the bond. This paragraph does not apply if the provider currently
256.9 maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

256.10 **Sec. 13. INFORMATION TECHNOLOGY PROJECTS; PERFORMANCE**
256.11 **REQUIREMENT.**

256.12 The commissioner of human services shall incorporate measurable indicators of progress
256.13 toward completion into every information technology project contract. The indicators of
256.14 progress toward completion must be periodic and at least measure progress for every 25
256.15 percent increment toward completion of the project. Every contract must withhold at least
256.16 ten percent of the total contract amount until the project is complete. The contract must
256.17 specify that in every instance where an indicator of progress toward completion is not met,
256.18 a specified proportion of the contract shall be withheld. The minimum amount withheld
256.19 shall be ten percent of the cumulative amount of the contract up to the date of the failure to
256.20 meet the indicator of progress toward completion. If an information technology project is
256.21 not completed on time according to the original contract, the commissioner shall reduce the
256.22 amount of the contract by ten percent.

256.23 **Sec. 14. EVALUATION OF GRANT PROGRAMS; PROVEN-EFFECTIVE**
256.24 **PRACTICES.**

256.25 (a) The commissioner of management and budget shall consult with the commissioner
256.26 of human services to establish a plan to review the services delivered under grant programs
256.27 administered by the commissioner of human services to determine whether the grant programs
256.28 prioritize proven-effective or promising practices.

256.29 (b) In accordance with the plan established in paragraph (a), the commissioner of
256.30 management and budget, in consultation with the commissioner of human services, shall
256.31 identify services to evaluate using an experimental or quasi-experimental design to provide
256.32 information needed to modify or develop grant programs to promote proven-effective
256.33 practices to improve the intended outcomes of the grant program.

257.1 (c) The commissioner of management and budget, in consultation with the commissioner
257.2 of human services, shall develop reports for the legislature and other stakeholders to provide
257.3 information on incorporating proven-effective practices in program and budget decisions.
257.4 The commissioner of management and budget, under Minnesota Statutes, section 15.08,
257.5 may obtain additional relevant data to support the evaluation activities under this section.

257.6 (d) For purposes of this section, the following terms have the meanings given:

257.7 (1) "proven-effective practice" means a service or practice that offers a high level of
257.8 research on effectiveness for at least one outcome of interest, as determined through multiple
257.9 evaluations outside of Minnesota or one or more local evaluation in Minnesota. The research
257.10 on effectiveness used to determine whether a service is proven-effective must use rigorously
257.11 implemented experimental or quasi-experimental designs; and

257.12 (2) "promising practices" means a service or practice that is supported by research
257.13 demonstrating effectiveness for at least one outcome of interest, and includes a single
257.14 evaluation that is not contradicted by other studies, but does not meet the full criteria for
257.15 the proven-effective designation. The research on effectiveness used to determine whether
257.16 a service is a promising practice must use rigorously implemented experimental or
257.17 quasi-experimental designs.

257.18 Sec. 15. **REVISOR INSTRUCTION.**

257.19 The revisor of statutes, in consultation with staff from the House Research Department;
257.20 House Fiscal Analysis; the Office of Senate Counsel, Research and Fiscal Analysis; and
257.21 the respective departments shall prepare legislation for introduction in the 2020 legislative
257.22 session proposing the statutory changes needed to implement the transfers of duties required
257.23 by Minnesota Statutes, sections 245I.01 and 245I.02.

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

257.25 Sec. 16. **REPEALER.**

257.26 Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 245G.11, subdivisions
257.27 1, 4, and 7, are repealed.

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

ARTICLE 8

DEPARTMENT OF HUMAN SERVICES; HEALTH CARE

258.1
258.2
258.3 Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

258.4 Subdivision 1. **Classifications.** (a) The following government data of the Department
258.5 of Public Safety are private data:

258.6 (1) medical data on driving instructors, licensed drivers, and applicants for parking
258.7 certificates and special license plates issued to physically disabled persons;

258.8 (2) other data on holders of a disability certificate under section 169.345, except that (i)
258.9 data that are not medical data may be released to law enforcement agencies, and (ii) data
258.10 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
258.11 enforcement employees or parking enforcement agents of statutory or home rule charter
258.12 cities and towns;

258.13 (3) Social Security numbers in driver's license and motor vehicle registration records,
258.14 except that Social Security numbers must be provided to the Department of Revenue for
258.15 purposes of tax administration, the Department of Labor and Industry for purposes of
258.16 workers' compensation administration and enforcement, the judicial branch for purposes of
258.17 debt collection, and the Department of Natural Resources for purposes of license application
258.18 administration, and except that the last four digits of the Social Security number must be
258.19 provided to the Department of Human Services for purposes of recovery of Minnesota health
258.20 care program benefits paid; and

258.21 (4) data on persons listed as standby or temporary custodians under section 171.07,
258.22 subdivision 11, except that the data must be released to:

258.23 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
258.24 caregiver; or

258.25 (ii) law enforcement agencies who state that the license holder is unable to communicate
258.26 at that time and that the information is necessary for notifying the designated caregiver of
258.27 the need to care for a child of the license holder.

258.28 The department may release the Social Security number only as provided in clause (3)
258.29 and must not sell or otherwise provide individual Social Security numbers or lists of Social
258.30 Security numbers for any other purpose.

258.31 (b) The following government data of the Department of Public Safety are confidential
258.32 data: data concerning an individual's driving ability when that data is received from a member
258.33 of the individual's family.

259.1 Sec. 2. [254A.21] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION
 259.2 GRANTS.

259.3 (a) The commissioner of human services shall award a grant to a statewide organization
 259.4 that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders.
 259.5 The grant recipient must make subgrants to eligible regional collaboratives in rural and
 259.6 urban areas of the state for the purposes specified in paragraph (c).

259.7 (b) "Eligible regional collaboratives" means a partnership between at least one local
 259.8 government and at least one community-based organization and, where available, a family
 259.9 home visiting program. For purposes of this paragraph, a local government includes a county
 259.10 or a multicounty organization, a tribal government, a county-based purchasing entity, or a
 259.11 community health board.

259.12 (c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of
 259.13 fetal alcohol spectrum disorders and other prenatal drug-related effects in children in
 259.14 Minnesota by identifying and serving pregnant women suspected of or known to use or
 259.15 abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services
 259.16 to chemically dependent women to increase positive birth outcomes.

259.17 (d) An eligible regional collaborative that receives a subgrant under this section must
 259.18 report to the grant recipient by January 15 of each year on the services and programs funded
 259.19 by the subgrant. The report must include measurable outcomes for the previous year,
 259.20 including the number of pregnant women served and the number of toxic-free babies born.
 259.21 The grant recipient must compile the information in the subgrant reports and submit a
 259.22 summary report to the commissioner of human services by February 15 of each year.

259.23 Sec. 3. Minnesota Statutes 2018, section 256.9365, is amended to read:

259.24 **256.9365 PURCHASE OF CONTINUATION HEALTH CARE COVERAGE FOR**
 259.25 **AIDS PATIENTS PEOPLE LIVING WITH HIV.**

259.26 Subdivision 1. **Program established.** The commissioner of human services shall establish
 259.27 a program to pay ~~private the cost of~~ health plan premiums and cost sharing for prescriptions,
 259.28 including co-payments, deductibles, and coinsurance for persons who have contracted human
 259.29 immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a
 259.30 group or individual health plan. If a person is determined to be eligible under subdivision
 259.31 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual~~
 259.32 ~~is responsible, if the individual is responsible for at least 50 percent of the cost of the~~
 259.33 ~~premium, or pay the individual plan premium~~ health insurance premiums and prescription

260.1 cost sharing, including co-payments and deductibles required under section 256B.0631.

260.2 The commissioner shall not pay for that portion of a premium that is attributable to other
260.3 family members or dependents or is paid by the individual's employer.

260.4 Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must
260.5 ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part
260.6 B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

260.7 ~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or~~
260.8 ~~physician assistant's statement verifying that the applicant is infected with HIV and is, or~~
260.9 ~~within three months is likely to become, too ill to work in the applicant's current employment~~
260.10 ~~because of HIV-related disease;~~

260.11 ~~(2) the applicant's monthly gross family income must not exceed 300 percent of the~~
260.12 ~~federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

260.13 ~~(3) the applicant must not own assets with a combined value of more than \$25,000; and~~

260.14 ~~(4) if applying for payment of group plan premiums, the applicant must be covered by~~
260.15 ~~an employer's or former employer's group insurance plan.~~

260.16 Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan
260.17 premiums under ~~subdivision 2, clause (5),~~ this section must be designed to ensure that the
260.18 state cost of paying an individual plan premium does not exceed the estimated state cost
260.19 that would otherwise be incurred in the medical assistance program. The commissioner
260.20 shall purchase the most cost-effective coverage available for eligible individuals.

260.21 Sec. 4. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

260.22 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and
260.23 feasible, the commissioner may utilize volume purchase through competitive bidding and
260.24 negotiation under the provisions of chapter 16C, to provide items under the medical assistance
260.25 program including but not limited to the following:

260.26 (1) eyeglasses;

260.27 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation
260.28 on a short-term basis, until the vendor can obtain the necessary supply from the contract
260.29 dealer;

260.30 (3) hearing aids and supplies; and

260.31 (4) durable medical equipment, including but not limited to:

- 261.1 (i) hospital beds;
- 261.2 (ii) commodes;
- 261.3 (iii) glide-about chairs;
- 261.4 (iv) patient lift apparatus;
- 261.5 (v) wheelchairs and accessories;
- 261.6 (vi) oxygen administration equipment;
- 261.7 (vii) respiratory therapy equipment;
- 261.8 (viii) electronic diagnostic, therapeutic and life-support systems;
- 261.9 (5) nonemergency medical transportation level of need determinations, disbursement of
- 261.10 public transportation passes and tokens, and volunteer and recipient mileage and parking
- 261.11 reimbursements; and
- 261.12 (6) drugs.
- 261.13 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not
- 261.14 affect contract payments under this subdivision unless specifically identified.
- 261.15 (c) The commissioner may not utilize volume purchase through competitive bidding
- 261.16 and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for
- 261.17 special transportation services or incontinence products and related supplies.
- 261.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.
- 261.19 Sec. 5. Minnesota Statutes 2018, section 256B.056, subdivision 1, is amended to read:
- 261.20 Subdivision 1. **Residency.** (a) To be eligible for medical assistance, a person must reside
- 261.21 in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota, in
- 261.22 accordance with Code of Federal Regulations, title 42, section 435.403.
- 261.23 (b) The commissioner shall identify individuals who are enrolled in medical assistance
- 261.24 and who are absent from the state for more than 30 consecutive days, but who continue to
- 261.25 qualify for medical assistance in accordance with paragraph (a).
- 261.26 (c) If the individual is absent from the state for more than 30 consecutive days but still
- 261.27 deemed a resident of Minnesota in accordance with paragraph (a), any covered service
- 261.28 provided to the individual must be paid through the fee-for-service system and not through
- 261.29 the managed care capitated rate payment system under section 256B.69 or 256L.12.

262.1 Sec. 6. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

262.2 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
262.3 assistance, a person must not individually own more than \$3,000 in assets, or if a member
262.4 of a household with two family members, husband and wife, or parent and child, the
262.5 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
262.6 dependent. In addition to these maximum amounts, an eligible individual or family may
262.7 accrue interest on these amounts, but they must be reduced to the maximum at the time of
262.8 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
262.9 according to section 256B.35 must also be reduced to the maximum at the time of the
262.10 eligibility redetermination. The value of assets that are not considered in determining
262.11 eligibility for medical assistance is the value of those assets excluded under the Supplemental
262.12 Security Income program for aged, blind, and disabled persons, with the following
262.13 exceptions:

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

262.15 (2) capital and operating assets of a trade or business that the local agency determines
262.16 are necessary to the person's ability to earn an income are not considered;

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

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

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

262.28 ~~(6) when a person enrolled in medical assistance under section 256B.057, subdivision~~
262.29 ~~9, is age 65 or older and has been enrolled during each of the 24 consecutive months before~~
262.30 ~~the person's 65th birthday, the assets owned by the person and the person's spouse must be~~
262.31 ~~disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when~~
262.32 ~~determining eligibility for medical assistance under section 256B.055, subdivision 7. a~~
262.33 designated employment incentives asset account is disregarded when determining eligibility
262.34 for medical assistance for a person age 65 years or older under section 256B.055, subdivision

263.1 7. An employment incentives asset account must only be designated by a person who has
 263.2 been enrolled in medical assistance under section 256B.057, subdivision 9, for a
 263.3 24-consecutive-month period. A designated employment incentives asset account contains
 263.4 qualified assets owned by the person and the person's spouse in the last month of enrollment
 263.5 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
 263.6 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
 263.7 other nonexcluded assets. An employment incentives asset account is no longer designated
 263.8 when a person loses medical assistance eligibility for a calendar month or more before
 263.9 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
 263.10 a new designated employment incentives asset account by establishing a new
 263.11 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
 263.12 income of a spouse of a person enrolled in medical assistance under section 256B.057,
 263.13 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
 263.14 must be disregarded when determining eligibility for medical assistance under section
 263.15 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
 263.16 in section 256B.059; and

263.17 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
 263.18 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
 263.19 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
 263.20 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

263.21 (b) Upon initial enrollment, no asset limit shall apply to persons eligible under section
 263.22 256B.055, subdivision 15. Upon renewal, a person eligible under section 256B.055,
 263.23 subdivision 15, must not own either individually or as a member of a household more than
 263.24 \$1,000,000 in assets to continue to be eligible for medical assistance.

263.25 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2019. Paragraph (b) is effective
 263.26 upon federal approval.

263.27 Sec. 7. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

263.28 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and
 263.29 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard
 263.30 specified in subdivision 4, paragraph (b).

263.31 (b) The excess income standard for a person whose eligibility is based on blindness,
 263.32 disability, or age of 65 or more years shall equal ~~81~~ 82 percent of the federal poverty
 263.33 guidelines. Effective July 1, 2021, the excess income standard for a person whose eligibility

264.1 is based on blindness disability, or age of 65 or more years, is the standard specified in
 264.2 subdivision 4, paragraph (a).

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

264.4 Sec. 8. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

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

264.10 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the
 264.11 commissioner must provide the enrollee with a prepopulated renewal form containing
 264.12 eligibility information available to the agency and permit the enrollee to submit the form
 264.13 with any corrections or additional information to the agency and sign the renewal form via
 264.14 any of the modes of submission specified in section 256B.04, subdivision 18.

264.15 (c) An enrollee who is terminated for failure to complete the renewal process may
 264.16 subsequently submit the renewal form and required information within four months after
 264.17 the date of termination and have coverage reinstated without a lapse, if otherwise eligible
 264.18 under this chapter. The local agency may close the enrollee's case file if the required
 264.19 information is not submitted within four months of termination.

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

264.22 Sec. 9. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

264.23 Subd. 9. **Dental services.** (a) Medical assistance covers dental services in accordance
 264.24 with this subdivision.

264.25 (b) Medical assistance dental coverage for ~~nonpregnant adults~~ adults who are eligible
 264.26 under section 256B.055, subdivision 7, is limited to the following services:

264.27 (1) comprehensive exams, limited to once every five years;

264.28 (2) periodic exams, limited to one per year;

264.29 (3) limited exams;

264.30 (4) bitewing x-rays, limited to one per year;

- 265.1 (5) periapical x-rays;
- 265.2 (6) panoramic x-rays, limited to one every five years except (1) when medically necessary
265.3 for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once
265.4 every two years for patients who cannot cooperate for intraoral film due to a developmental
265.5 disability or medical condition that does not allow for intraoral film placement;
- 265.6 (7) prophylaxis, limited to one per year;
- 265.7 (8) application of fluoride varnish, limited to one per year;
- 265.8 (9) posterior fillings, all at the amalgam rate;
- 265.9 (10) anterior fillings;
- 265.10 (11) endodontics, limited to root canals on the anterior and premolars only;
- 265.11 (12) removable prostheses, each dental arch limited to one every six years;
- 265.12 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;
- 265.13 (14) palliative treatment and sedative fillings for relief of pain; and
- 265.14 (15) full-mouth debridement, limited to one every five years.
- 265.15 (c) In addition to the services specified in paragraph (b), medical assistance covers the
265.16 following services for adults, if provided in an outpatient hospital setting or freestanding
265.17 ambulatory surgical center as part of outpatient dental surgery:
- 265.18 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 265.19 (2) general anesthesia; and
- 265.20 (3) full-mouth survey once every five years.
- 265.21 ~~(d)~~ (a) Medical assistance covers medically necessary dental services for children and
265.22 pregnant women. The following guidelines apply:
- 265.23 (1) posterior fillings are paid at the amalgam rate;
- 265.24 (2) application of sealants are covered once every five years per permanent molar for
265.25 children only;
- 265.26 (3) application of fluoride varnish is covered once every six months; and
- 265.27 (4) orthodontia is eligible for coverage for children only.
- 265.28 ~~(e)~~ (b) In addition to the services specified in paragraphs (b) and (c), medical assistance
265.29 covers the following services for adults:

266.1 (1) house calls or extended care facility calls for on-site delivery of covered services;

266.2 (2) behavioral management when additional staff time is required to accommodate
266.3 behavioral challenges and sedation is not used;

266.4 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
266.5 it or would otherwise require the service to be performed under general anesthesia in a
266.6 hospital or surgical center; and

266.7 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
266.8 no more than four times per year.

266.9 ~~(f)~~ (c) The commissioner shall not require prior authorization for the services included
266.10 in paragraph ~~(e)~~ (b), clauses (1) to (3), and shall prohibit managed care and county-based
266.11 purchasing plans from requiring prior authorization for the services included in paragraph
266.12 ~~(e)~~ (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

266.13 Sec. 10. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to read:

266.14 Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers
266.15 ~~eyeglasses, dentures, and~~ prosthetic devices if prescribed by a licensed practitioner.

266.16 (b) Medical assistance covers vision services, eyeglasses, and dentures for children and
266.17 adults eligible under section 256B.055, subdivision 7, if prescribed by a licensed practitioner.

266.18 Sec. 11. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

266.19 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
266.20 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
266.21 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
266.22 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed
266.23 by or under contract with a community health board as defined in section 145A.02,
266.24 subdivision 5, for the purposes of communicable disease control.

266.25 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
266.26 unless authorized by the commissioner.

266.27 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
266.28 ingredient" is defined as a substance that is represented for use in a drug and when used in
266.29 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
266.30 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
266.31 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

267.1 excipients which are included in the medical assistance formulary. Medical assistance covers
267.2 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
267.3 when the compounded combination is specifically approved by the commissioner or when
267.4 a commercially available product:

267.5 (1) is not a therapeutic option for the patient;

267.6 (2) does not exist in the same combination of active ingredients in the same strengths
267.7 as the compounded prescription; and

267.8 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
267.9 prescription.

267.10 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
267.11 a licensed practitioner or by a licensed pharmacist who meets standards established by the
267.12 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
267.13 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
267.14 with documented vitamin deficiencies, vitamins for children under the age of seven and
267.15 pregnant or nursing women, and any other over-the-counter drug identified by the
267.16 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
267.17 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
267.18 disorders, and this determination shall not be subject to the requirements of chapter 14. A
267.19 pharmacist may prescribe over-the-counter medications as provided under this paragraph
267.20 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
267.21 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
267.22 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
267.23 and make referrals as needed to other health care professionals. ~~Over-the-counter medications
267.24 must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained
267.25 in the manufacturer's original package; (2) the number of dosage units required to complete
267.26 the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed
267.27 from a system using retrospective billing, as provided under subdivision 13c, paragraph
267.28 (b).~~

267.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
267.30 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
267.31 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
267.32 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
267.33 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
267.34 individuals, medical assistance may cover drugs from the drug classes listed in United States

268.1 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
 268.2 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
 268.3 not be covered.

268.4 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
 268.5 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
 268.6 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
 268.7 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

268.8 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
 268.9 whichever is later. The commissioner of human services shall notify the revisor of statutes
 268.10 when federal approval is obtained.

268.11 Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to
 268.12 read:

268.13 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
 268.14 be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable~~
 268.15 ~~cost by the commissioner~~ plus the fixed professional dispensing fee; or the usual and
 268.16 customary price charged to the public. The usual and customary price means the lowest
 268.17 price charged by the provider to a patient who pays for the prescription by cash, check, or
 268.18 charge account and includes prices the pharmacy charges to a patient enrolled in a
 268.19 prescription savings club or prescription discount club administered by the pharmacy or
 268.20 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
 268.21 amounts applied to the charge by any third-party provider/insurer agreement or contract for
 268.22 submitted charges to medical assistance programs. The net submitted charge may not be
 268.23 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee
 268.24 shall be ~~\$3.65~~ \$10.48 for ~~legend prescription drugs, except that prescriptions filled with~~
 268.25 legend drugs meeting the definition of "covered outpatient drugs" according to United States
 268.26 Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~
 268.27 that must be compounded by the pharmacist shall be \$8 \$10.48 per bag; ~~\$14 per bag for~~
 268.28 ~~cancer chemotherapy products, and \$30 per bag for total parenteral nutritional products~~
 268.29 ~~dispensed in one-liter quantities, or \$44 per bag for total parenteral nutritional products~~
 268.30 ~~dispensed in quantities greater than one liter.~~ The professional dispensing fee for
 268.31 prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient
 268.32 drugs shall be \$10.48 for dispensed quantities equal to or greater than the number of units
 268.33 contained in the manufacturer's original package. The professional dispensing fee shall be
 268.34 prorated based on the percentage of the package dispensed when the pharmacy dispenses

269.1 a quantity less than the number of units contained in the manufacturer's original package.
269.2 The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition
269.3 of covered outpatient drugs shall be \$3.65, ~~except that the fee shall be \$1.31 for~~
269.4 ~~retrospectively billing pharmacies when billing for quantities less than the number of units~~
269.5 ~~contained in the manufacturer's original package. Actual acquisition cost includes quantity~~
269.6 ~~and other special discounts except time and cash discounts. The actual acquisition cost of~~
269.7 ~~a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent~~
269.8 ~~for independently owned pharmacies located in a designated rural area within Minnesota,~~
269.9 ~~and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is~~
269.10 ~~"independently owned" if it is one of four or fewer pharmacies under the same ownership~~
269.11 ~~nationally. A "designated rural area" means an area defined as a small rural area or isolated~~
269.12 ~~rural area according to the four-category classification of the Rural Urban Commuting Area~~
269.13 ~~system developed for the United States Health Resources and Services Administration.~~
269.14 Effective January 1, 2014, the actual acquisition for quantities equal to or greater than the
269.15 number of units contained in the manufacturer's original package and shall be prorated based
269.16 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
269.17 than the number of units contained in the manufacturer's original package. The National
269.18 Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost
269.19 of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate
269.20 the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost
269.21 of a drug acquired through for a provider participating in the federal 340B Drug Pricing
269.22 Program shall be estimated by the commissioner at wholesale acquisition cost minus 40
269.23 percent either the 340B Drug Pricing Program ceiling price established by the Health
269.24 Resources and Services Administration or NADAC, whichever is lower. Wholesale
269.25 acquisition cost is defined as the manufacturer's list price for a drug or biological to
269.26 wholesalers or direct purchasers in the United States, not including prompt pay or other
269.27 discounts, rebates, or reductions in price, for the most recent month for which information
269.28 is available, as reported in wholesale price guides or other publications of drug or biological
269.29 pricing data. The maximum allowable cost of a multisource drug may be set by the
269.30 commissioner and it shall be comparable to, but the actual acquisition cost of the drug
269.31 product and no higher than, the maximum amount paid by other third-party payors in this
269.32 state who have maximum allowable cost programs the NADAC of the generic product.
269.33 Establishment of the amount of payment for drugs shall not be subject to the requirements
269.34 of the Administrative Procedure Act.

269.35 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
269.36 an automated drug distribution system meeting the requirements of section 151.58, or a

270.1 packaging system meeting the packaging standards set forth in Minnesota Rules, part
270.2 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
270.3 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
270.4 retrospectively billing pharmacy must submit a claim only for the quantity of medication
270.5 used by the enrolled recipient during the defined billing period. A retrospectively billing
270.6 pharmacy must use a billing period not less than one calendar month or 30 days.

270.7 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~
270.8 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~
270.9 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~
270.10 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~
270.11 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~
270.12 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~
270.13 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~
270.14 ~~of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets
270.15 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the
270.16 department for the actual acquisition cost of all unused drugs that are eligible for reuse,
270.17 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
270.18 clozapine to be dispensed in a quantity that is less than a 30-day supply.

270.19 (d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a
270.20 multisource drug, payment shall be the lower of the usual and customary price charged to
270.21 the public or the ingredient cost shall be the NADAC of the generic product or the maximum
270.22 allowable cost established by the commissioner unless prior authorization for the brand
270.23 name product has been granted according to the criteria established by the Drug Formulary
270.24 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated
270.25 "dispense as written" on the prescription in a manner consistent with section 151.21,
270.26 subdivision 2.

270.27 (e) The basis for determining the amount of payment for drugs administered in an
270.28 outpatient setting shall be the lower of the usual and customary cost submitted by the
270.29 provider, 106 percent of the average sales price as determined by the United States
270.30 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
270.31 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
270.32 set by the commissioner. If average sales price is unavailable, the amount of payment must
270.33 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
270.34 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
270.35 ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs

271.1 obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment
271.2 for drugs administered in an outpatient setting shall be made to the administering facility
271.3 or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
271.4 outpatient setting is not eligible for direct reimbursement.

271.5 (f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable
271.6 cost rates for specialty pharmacy products than the rates that are lower than the ingredient
271.7 cost formulas specified in paragraph (a). The commissioner may require individuals enrolled
271.8 in the health care programs administered by the department to obtain specialty pharmacy
271.9 products from providers with whom the commissioner has negotiated lower reimbursement
271.10 rates. Specialty pharmacy products are defined as those used by a small number of recipients
271.11 or recipients with complex and chronic diseases that require expensive and challenging drug
271.12 regimens. Examples of these conditions include, but are not limited to: multiple sclerosis,
271.13 HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease,
271.14 rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include
271.15 injectable and infusion therapies, biotechnology drugs, antihemophilic factor products,
271.16 high-cost therapies, and therapies that require complex care. The commissioner shall consult
271.17 with the Formulary Committee to develop a list of specialty pharmacy products subject to
271.18 ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary
271.19 Committee in developing this list, the commissioner shall take into consideration the
271.20 population served by specialty pharmacy products, the current delivery system and standard
271.21 of care in the state, and access to care issues. The commissioner shall have the discretion
271.22 to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

271.23 (g) Home infusion therapy services provided by home infusion therapy pharmacies must
271.24 be paid at rates according to subdivision 8d.

271.25 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
271.26 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
271.27 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
271.28 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
271.29 department to dispense outpatient prescription drugs to fee-for-service members must
271.30 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
271.31 section 256B.064 for failure to respond. The commissioner shall require the vendor to
271.32 measure a single statewide cost of dispensing for all responding pharmacies to measure the
271.33 mean, mean weighted by total prescription volume, mean weighted by medical assistance
271.34 prescription volume, median, median weighted by total prescription volume, and median
271.35 weighted by total medical assistance prescription volume. The commissioner shall post a

272.1 copy of the final cost of dispensing survey report on the department's website. The initial
 272.2 survey must be completed no later than January 1, 2021, and repeated every three years.
 272.3 The commissioner shall provide a summary of the results of each cost of dispensing survey
 272.4 and provide recommendations for any changes to the dispensing fee to the chairs and ranking
 272.5 members of the legislative committees with jurisdiction over medical assistance pharmacy
 272.6 reimbursement.

272.7 **EFFECTIVE DATE.** This section is effective April 1, 2019, or upon federal approval,
 272.8 whichever is later. The commissioner of human services shall inform the revisor of statutes
 272.9 when federal approval is obtained or denied.

272.10 Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

272.11 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
 272.12 recommend drugs which require prior authorization. The Formulary Committee shall
 272.13 establish general criteria to be used for the prior authorization of brand-name drugs for
 272.14 which generically equivalent drugs are available, but the committee is not required to review
 272.15 each brand-name drug for which a generically equivalent drug is available.

272.16 (b) Prior authorization may be required by the commissioner before certain formulary
 272.17 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
 272.18 authorization directly to the commissioner. The commissioner may also request that the
 272.19 Formulary Committee review a drug for prior authorization. Before the commissioner may
 272.20 require prior authorization for a drug:

272.21 (1) the commissioner must provide information to the Formulary Committee on the
 272.22 impact that placing the drug on prior authorization may have on the quality of patient care
 272.23 and on program costs, information regarding whether the drug is subject to clinical abuse
 272.24 or misuse, and relevant data from the state Medicaid program if such data is available;

272.25 (2) the Formulary Committee must review the drug, taking into account medical and
 272.26 clinical data and the information provided by the commissioner; and

272.27 (3) the Formulary Committee must hold a public forum and receive public comment for
 272.28 an additional 15 days.

272.29 The commissioner must provide a 15-day notice period before implementing the prior
 272.30 authorization.

272.31 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
 272.32 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
 272.33 if:

273.1 (1) there is no generically equivalent drug available; and

273.2 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

273.3 (3) the drug is part of the recipient's current course of treatment.

273.4 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
 273.5 program established or administered by the commissioner. Prior authorization shall
 273.6 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
 273.7 illness within 60 days of when a generically equivalent drug becomes available, provided
 273.8 that the brand name drug was part of the recipient's course of treatment at the time the
 273.9 generically equivalent drug became available.

273.10 ~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor~~
 273.11 ~~drug prescribed for the treatment of hemophilia and blood disorders where there is no~~
 273.12 ~~generically equivalent drug available if the prior authorization is used in conjunction with~~
 273.13 ~~any supplemental drug rebate program or multistate preferred drug list established or~~
 273.14 ~~administered by the commissioner.~~

273.15 ~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever
 273.16 a generically equivalent product is available, even if the prescriber specifically indicates
 273.17 "dispense as written-brand necessary" on the prescription as required by section 151.21,
 273.18 subdivision 2.

273.19 ~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require
 273.20 prior authorization, for a period not to exceed 180 days, for any drug that is approved by
 273.21 the United States Food and Drug Administration on or after July 1, 2005. The 180-day
 273.22 period begins no later than the first day that a drug is available for shipment to pharmacies
 273.23 within the state. The Formulary Committee shall recommend to the commissioner general
 273.24 criteria to be used for the prior authorization of the drugs, but the committee is not required
 273.25 to review each individual drug. In order to continue prior authorizations for a drug after the
 273.26 180-day period has expired, the commissioner must follow the provisions of this subdivision.

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

273.28 Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 18d, is amended to
 273.29 read:

273.30 Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical
 273.31 Transportation Advisory Committee consists of:

274.1 (1) four voting members who represent counties, utilizing the rural urban commuting
274.2 area classification system. As defined in subdivision 17, these members shall be designated
274.3 as follows:

274.4 (i) two counties within the 11-county metropolitan area;

274.5 (ii) one county representing the rural area of the state; and

274.6 (iii) one county representing the super rural area of the state.

274.7 The Association of Minnesota Counties shall appoint one county within the 11-county
274.8 metropolitan area and one county representing the super rural area of the state. The Minnesota
274.9 Inter-County Association shall appoint one county within the 11-county metropolitan area
274.10 and one county representing the rural area of the state;

274.11 (2) three voting members who represent medical assistance recipients, including persons
274.12 with physical and developmental disabilities, persons with mental illness, seniors, children,
274.13 and low-income individuals;

274.14 (3) ~~four~~ five voting members who represent providers that deliver nonemergency medical
274.15 transportation services to medical assistance enrollees, one of whom is a taxicab owner or
274.16 operator;

274.17 (4) two voting members of the house of representatives, one from the majority party and
274.18 one from the minority party, appointed by the speaker of the house, and two voting members
274.19 from the senate, one from the majority party and one from the minority party, appointed by
274.20 the Subcommittee on Committees of the Committee on Rules and Administration;

274.21 (5) one voting member who represents demonstration providers as defined in section
274.22 256B.69, subdivision 2;

274.23 (6) one voting member who represents an organization that contracts with state or local
274.24 governments to coordinate transportation services for medical assistance enrollees;

274.25 (7) one voting member who represents the Minnesota State Council on Disability;

274.26 (8) the commissioner of transportation or the commissioner's designee, who shall serve
274.27 as a voting member;

274.28 (9) one voting member appointed by the Minnesota Ambulance Association; and

274.29 (10) one voting member appointed by the Minnesota Hospital Association.

274.30 (b) Members of the advisory committee shall not be employed by the Department of
274.31 Human Services. Members of the advisory committee shall receive no compensation.

275.1 Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
275.2 to read:

275.3 Subd. 66. **Prescribed pediatric extended care (PPEC) center basic services.** Medical
275.4 assistance covers PPEC center basic services as defined under section 144H.01, subdivision
275.5 2. PPEC basic services shall be reimbursed according to section 256B.86.

275.6 **EFFECTIVE DATE.** This section is effective July 1, 2020, or upon federal approval,
275.7 whichever occurs later. The commissioner of human services shall notify the commissioner
275.8 of health and the revisor of statutes when federal approval is obtained.

275.9 Sec. 16. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

275.10 Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose
275.11 sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse
275.12 in connection with the provision of medical care to recipients of public assistance; (2) a
275.13 pattern of presentment of false or duplicate claims or claims for services not medically
275.14 necessary; (3) a pattern of making false statements of material facts for the purpose of
275.15 obtaining greater compensation than that to which the vendor is legally entitled; (4)
275.16 suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access
275.17 during regular business hours to examine all records necessary to disclose the extent of
275.18 services provided to program recipients and appropriateness of claims for payment; (6)
275.19 failure to repay an overpayment or a fine finally established under this section; (7) failure
275.20 to correct errors in the maintenance of health service or financial records for which a fine
275.21 was imposed or after issuance of a warning by the commissioner; and (8) any reason for
275.22 which a vendor could be excluded from participation in the Medicare program under section
275.23 1128, 1128A, or 1866(b)(2) of the Social Security Act.

275.24 (b) The commissioner may impose sanctions against a pharmacy provider for failure to
275.25 respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph
275.26 (h).

275.27 **EFFECTIVE DATE.** This section is effective April 1, 2019.

275.28 Sec. 17. Minnesota Statutes 2018, section 256B.69, subdivision 4, is amended to read:

275.29 Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine
275.30 when limitation of choice may be implemented in the experimental counties. The criteria
275.31 shall ensure that all eligible individuals in the county have continuing access to the full
275.32 range of medical assistance services as specified in subdivision 6.

276.1 (b) The commissioner shall exempt the following persons from participation in the
276.2 project, in addition to those who do not meet the criteria for limitation of choice:

276.3 (1) persons eligible for medical assistance according to section 256B.055, subdivision
276.4 1;

276.5 (2) persons eligible for medical assistance due to blindness or disability as determined
276.6 by the Social Security Administration or the state medical review team, unless:

276.7 (i) they are 65 years of age or older; or

276.8 (ii) they reside in Itasca County or they reside in a county in which the commissioner
276.9 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social
276.10 Security Act;

276.11 (3) recipients who currently have private coverage through a health maintenance
276.12 organization;

276.13 (4) recipients who are eligible for medical assistance by spending down excess income
276.14 for medical expenses other than the nursing facility per diem expense;

276.15 (5) recipients who receive benefits under the Refugee Assistance Program, established
276.16 under United States Code, title 8, section 1522(e);

276.17 (6) children who are both determined to be severely emotionally disturbed and receiving
276.18 case management services according to section 256B.0625, subdivision 20, except children
276.19 who are eligible for and who decline enrollment in an approved preferred integrated network
276.20 under section 245.4682;

276.21 (7) adults who are both determined to be seriously and persistently mentally ill and
276.22 received case management services according to section 256B.0625, subdivision 20;

276.23 (8) persons eligible for medical assistance according to section 256B.057, subdivision
276.24 10; ~~and~~

276.25 (9) persons with access to cost-effective employer-sponsored private health insurance
276.26 or persons enrolled in a non-Medicare individual health plan determined to be cost-effective
276.27 according to section 256B.0625, subdivision 15; and

276.28 (10) persons who are absent from the state for more than 30 consecutive days but still
276.29 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
276.30 1, paragraph (b).

276.31 Children under age 21 who are in foster placement may enroll in the project on an elective
276.32 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective

277.1 basis. The commissioner may enroll recipients in the prepaid medical assistance program
277.2 for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending
277.3 down excess income.

277.4 (c) The commissioner may allow persons with a one-month spenddown who are otherwise
277.5 eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly
277.6 spenddown to the state.

277.7 (d) The commissioner may require those individuals to enroll in the prepaid medical
277.8 assistance program who otherwise would have been excluded under paragraph (b), clauses
277.9 (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

277.10 (e) Before limitation of choice is implemented, eligible individuals shall be notified and
277.11 after notification, shall be allowed to choose only among demonstration providers. The
277.12 commissioner may assign an individual with private coverage through a health maintenance
277.13 organization, to the same health maintenance organization for medical assistance coverage,
277.14 if the health maintenance organization is under contract for medical assistance in the
277.15 individual's county of residence. After initially choosing a provider, the recipient is allowed
277.16 to change that choice only at specified times as allowed by the commissioner. If a
277.17 demonstration provider ends participation in the project for any reason, a recipient enrolled
277.18 with that provider must select a new provider but may change providers without cause once
277.19 more within the first 60 days after enrollment with the second provider.

277.20 (f) An infant born to a woman who is eligible for and receiving medical assistance and
277.21 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to
277.22 the month of birth in the same managed care plan as the mother once the child is enrolled
277.23 in medical assistance unless the child is determined to be excluded from enrollment in a
277.24 prepaid plan under this section.

277.25 Sec. 18. Minnesota Statutes 2018, section 256B.69, subdivision 31, is amended to read:

277.26 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
277.27 shall reduce payments and limit future rate increases paid to managed care plans and
277.28 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a
277.29 statewide aggregate basis by program. The commissioner may use competitive bidding,
277.30 payment reductions, or other reductions to achieve the reductions and limits in this
277.31 subdivision.

277.32 (b) Beginning September 1, 2011, the commissioner shall reduce payments to managed
277.33 care plans and county-based purchasing plans as follows:

278.1 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare
278.2 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

278.3 (2) 2.82 percent for medical assistance families and children;

278.4 (3) 10.1 percent for medical assistance adults without children; and

278.5 (4) 6.0 percent for MinnesotaCare families and children.

278.6 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care
278.7 plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates
278.8 in effect on August 31, 2011, as follows:

278.9 (1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare
278.10 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

278.11 (2) 97.18 percent for medical assistance families and children;

278.12 (3) 89.9 percent for medical assistance adults without children; and

278.13 (4) 94 percent for MinnesotaCare families and children.

278.14 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the
278.15 maximum annual trend increases to rates paid to managed care plans and county-based
278.16 purchasing plans as follows:

278.17 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare
278.18 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

278.19 (2) 5.0 percent for medical assistance special needs basic care;

278.20 (3) 2.0 percent for medical assistance families and children;

278.21 (4) 3.0 percent for medical assistance adults without children;

278.22 (5) 3.0 percent for MinnesotaCare families and children; and

278.23 (6) 3.0 percent for MinnesotaCare adults without children.

278.24 (e) The commissioner may limit trend increases to less than the maximum. Beginning
278.25 July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid
278.26 to managed care plans and county-based purchasing plans as follows for calendar years
278.27 2014 and 2015:

278.28 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare
278.29 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

278.30 (2) 5.0 percent for medical assistance special needs basic care;

279.1 (3) 2.0 percent for medical assistance families and children;

279.2 (4) 3.0 percent for medical assistance adults without children;

279.3 (5) 3.0 percent for MinnesotaCare families and children; and

279.4 (6) 4.0 percent for MinnesotaCare adults without children.

279.5 (f) The commissioner may limit trend increases to less than the maximum. For calendar
 279.6 year 2014, the commissioner shall reduce the maximum aggregate trend increases by
 279.7 \$47,000,000 in state and federal funds to account for the reductions in administrative
 279.8 expenses in subdivision 5i.

279.9 (g) Beginning January 1, 2020, to December 31, 2024, the commissioner shall limit the
 279.10 maximum annual trend increases to rates paid to managed care plans and county-based
 279.11 purchasing plans as follows for calendar years 2020, 2021, 2023, and 2024:

279.12 (1) 3.4 percent for medical assistance elderly basic care. This shall not apply to Medicare
 279.13 cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

279.14 (2) 3.4 percent for medical assistance special needs basic care;

279.15 (3) 2.4 percent for medical assistance families and children; and

279.16 (4) 2.4 percent for medical assistance adults without children.

279.17 Sec. 19. **[256B.86] PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTER**
 279.18 **SERVICES.**

279.19 Subdivision 1. **Reimbursement rates.** The daily per-child payment rates for PPEC basic
 279.20 services covered by medical assistance and provided at PPEC centers licensed under chapter
 279.21 144H are:

279.22 (1) for intense complexity: \$550 for four or more hours and \$275 for less than four hours;

279.23 (2) for high complexity: \$450 for four or more hours and \$225 for less than four hours;

279.24 and

279.25 (3) for moderate complexity: \$400 for four or more hours and \$200 for less than four
 279.26 hours.

279.27 Subd. 2. **Determination of complexity level.** Complexity level shall be determined
 279.28 based on the level of nursing intervention required for each child using an assessment tool
 279.29 approved by the commissioner.

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

280.4 Sec. 20. Minnesota Statutes 2018, section 256L.03, subdivision 5, is amended to read:

280.5 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
280.6 children under the age of 21 and to American Indians as defined in Code of Federal
280.7 Regulations, title 42, section 600.5.

280.8 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
280.9 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent
280.10 for families or individuals with incomes equal to or below 150 percent of the federal poverty
280.11 guidelines; and to 87 percent for families or individuals with incomes that are above 150
280.12 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal
280.13 poverty guidelines for the applicable family size. The cost-sharing changes described in
280.14 this paragraph do not apply to eligible recipients or services exempt from cost-sharing under
280.15 state law. The cost-sharing changes described in this paragraph shall not be implemented
280.16 prior to January 1, 2016.

280.17 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
280.18 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
280.19 title 42, sections 600.510 and 600.520.

280.20 Sec. 21. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision
280.21 to read:

280.22 Subd. 7. **Minnesota EHB Benchmark Plan.** Notwithstanding subdivisions 1, 2, 3, 3a,
280.23 and 3b, and section 256L.12, or any other law to the contrary, the services covered for
280.24 parents, caretakers, foster parents, or legal guardians and single adults without children
280.25 eligible for MinnesotaCare under section 256L.04 shall be the services covered under the
280.26 Minnesota EHB Benchmark Plan for plan year 2016 or the actuarial equivalent.

280.27 Sec. 22. **CORRECTIVE PLAN TO ELIMINATE DUPLICATE PERSONAL**
280.28 **IDENTIFICATION NUMBERS.**

280.29 (a) The commissioner of human services shall design and implement a corrective plan
280.30 to address the issue of medical assistance enrollees being assigned more than one personal
280.31 identification number. Any corrections or fixes that are necessary to address this issue are
280.32 required to be completed by June 30, 2021.

281.1 (b) By February 15, 2020, the commissioner shall submit a report to the chairs and
 281.2 ranking minority members of the legislative committees with jurisdiction over health and
 281.3 human services policy and finance on the progress of the corrective plan required in paragraph
 281.4 (a), including an update on meeting the June 30, 2021, deadline. The report must also include
 281.5 information on:

281.6 (1) the number of medical assistance enrollees who have been assigned two or more
 281.7 personal identification numbers;

281.8 (2) any possible financial effect of enrollees having duplicate personal identification
 281.9 numbers on health care providers and managed care organizations, including the effect on
 281.10 reimbursement rates, meeting withhold requirements, and capitated payments; and

281.11 (3) any effect on federal payments received by the state.

281.12 **Sec. 23. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
 281.13 **QUALITY MEASURES FOR PRESCRIBED PEDIATRIC EXTENDED CARE**
 281.14 **(PPEC) CENTERS.**

281.15 (a) The commissioner of human services, in consultation with community stakeholders
 281.16 as defined by the commissioner and PPEC centers licensed prior to June 30, 2024, shall
 281.17 develop quality measures for PPEC centers, procedures for PPEC centers to report quality
 281.18 measures to the commissioner, and methods for the commissioner to make the results of
 281.19 the quality measures available to the public.

281.20 (b) The commissioner of human services shall submit by February 1, 2024, a report on
 281.21 the topics described in paragraph (a) to the chairs and ranking minority members of the
 281.22 legislative committees with jurisdiction over health and human services.

281.23 **EFFECTIVE DATE.** This section is effective upon the effective date of section 13.

281.24 **Sec. 24. PAIN MANAGEMENT.**

281.25 (a) The Health Services Policy Committee established under Minnesota Statutes, section
 281.26 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration
 281.27 of nonpharmacologic pain management that are clinically viable and sustainable; reduce or
 281.28 eliminate chronic pain conditions; improve functional status; and prevent addiction and
 281.29 reduce dependence on opiates or other pain medications. The recommendations must be
 281.30 based on best practices for the effective treatment of musculoskeletal pain provided by
 281.31 health practitioners identified in paragraph (b), and covered under medical assistance. Each
 281.32 health practitioner represented under paragraph (b) shall present the minimum best integrated

282.1 practice recommendations, policies, and scientific evidence for nonpharmacologic treatment
 282.2 options for eliminating pain and improving functional status within their full professional
 282.3 scope. Recommendations for integration of services may include guidance regarding
 282.4 screening for co-occurring behavioral health diagnoses; protocols for communication between
 282.5 all providers treating a unique individual, including protocols for follow-up; and universal
 282.6 mechanisms to assess improvements in functional status.

282.7 (b) In evaluating and making recommendations, the Health Services Policy Committee
 282.8 shall consult and collaborate with the following health practitioners: acupuncture practitioners
 282.9 licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota
 282.10 Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes,
 282.11 sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota
 282.12 Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota
 282.13 Statutes, sections 148.171 to 148.285, with experience in providing primary care
 282.14 collaboratively within a multidisciplinary team of health care practitioners who employ
 282.15 nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes,
 282.16 section 148.907.

282.17 (c) The commissioner shall submit a progress report to the chairs and ranking minority
 282.18 members of the legislative committees with jurisdiction over health and human services
 282.19 policy and finance by January 15, 2020, and shall report final recommendations by August
 282.20 1, 2020. The final report may also contain recommendations for developing and implementing
 282.21 a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated
 282.22 nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and
 282.23 improving functional status.

282.24 Sec. 25. **REPEALER.**

282.25 Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 256B.0625, subdivision
 282.26 31c, are repealed.

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

282.28 **ARTICLE 9**

282.29 **DEPARTMENT OF HEALTH**

282.30 Section 1. **[8.40] LITIGATION DEFENSE FUND.**

282.31 (a) There is created in the special revenue fund an account entitled the Pain-Capable
 282.32 Unborn Child Protection Act litigation account for the purpose of providing funds to pay

283.1 for any costs and expenses incurred by the state attorney general in relation to actions
 283.2 surrounding defense of sections 145.4141 to 145.4147.

283.3 (b) The account shall be maintained by the commissioner of management and budget.

283.4 (c) The litigation account shall consist of:

283.5 (1) appropriations made to the account by the legislature; and

283.6 (2) any donations, gifts, or grants made to the account by private citizens or entities.

283.7 (d) The litigation account shall retain the interest income derived from the money credited
 283.8 to the account.

283.9 (e) Any funds in the litigation account are appropriated to the attorney general for the
 283.10 purposes described in paragraph (a).

283.11 Sec. 2. Minnesota Statutes 2018, section 18K.03, is amended to read:

283.12 **18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.**

283.13 Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A
 283.14 person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant
 283.15 to this chapter.

283.16 Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may
 283.17 sell hemp products derived from industrial hemp grown in this state to medical cannabis
 283.18 manufacturers as authorized under sections 152.22 to 152.37.

283.19 Sec. 3. Minnesota Statutes 2018, section 62J.495, subdivision 1, is amended to read:

283.20 Subdivision 1. **Implementation.** ~~By January 1, 2015, all hospitals and health care~~
 283.21 ~~providers, as defined in section 62J.03, subdivision 8, must have in place an interoperable~~
 283.22 ~~electronic health records system within their hospital system or clinical practice setting.~~

283.23 The commissioner of health, in consultation with the e-Health Advisory Committee, shall
 283.24 develop a statewide plan to meet this goal, including uniform standards to be used for the
 283.25 interoperable electronic health records system for sharing and synchronizing patient data
 283.26 across systems. The standards must be compatible with federal efforts. The uniform standards
 283.27 must be developed by January 1, 2009, and updated on an ongoing basis. The commissioner
 283.28 shall include an update on standards development as part of an annual report to the legislature.
 283.29 Individual health care providers in private practice with no other providers and health care
 283.30 providers that do not accept reimbursement from a group purchaser, as defined in section
 283.31 62J.03, subdivision 6, are excluded from the requirements of this section.

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

284.2 Sec. 4. Minnesota Statutes 2018, section 62J.495, subdivision 3, is amended to read:

284.3 Subd. 3. **Interoperable electronic health record requirements.** (a) ~~To meet the~~
 284.4 ~~requirements of subdivision 1,~~ Hospitals and health care providers must meet the following
 284.5 criteria when implementing an interoperable electronic health records system within their
 284.6 hospital system or clinical practice setting.

284.7 (b) The electronic health record must be a qualified electronic health record.

284.8 (c) The electronic health record must be certified by the Office of the National
 284.9 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health
 284.10 care providers if a certified electronic health record product for the provider's particular
 284.11 practice setting is available. This criterion shall be considered met if a hospital or health
 284.12 care provider is using an electronic health records system that has been certified within the
 284.13 last three years, even if a more current version of the system has been certified within the
 284.14 three-year period.

284.15 (d) The electronic health record must meet the standards established according to section
 284.16 3004 of the HITECH Act as applicable.

284.17 (e) The electronic health record must have the ability to generate information on clinical
 284.18 quality measures and other measures reported under sections 4101, 4102, and 4201 of the
 284.19 HITECH Act.

284.20 (f) The electronic health record system must be connected to a state-certified health
 284.21 information organization either directly or through a connection facilitated by a state-certified
 284.22 health data intermediary as defined in section 62J.498.

284.23 (g) A health care provider who is a prescriber or dispenser of legend drugs must have
 284.24 an electronic health record system that meets the requirements of section 62J.497.

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

284.26 Sec. 5. **[62J.84] PRESCRIPTION DRUG PRICE TRANSPARENCY.**

284.27 Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price
 284.28 Transparency Act."

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

284.31 (b) "Commissioner" means the commissioner of health.

285.1 (c) "Manufacturer" means a drug manufacturer licensed under section 151.252.

285.2 (d) "New prescription drug" means a prescription drug approved for marketing by the
285.3 United States Food and Drug Administration for which no previous wholesale acquisition
285.4 cost has been established for comparison.

285.5 (e) "Patient assistance program" means a program that a manufacturer offers to the public
285.6 in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs
285.7 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other
285.8 means.

285.9 (f) "Prescription drug" or "drug" has the meaning provided in section 151.44, paragraph
285.10 (d).

285.11 (g) "Price" means the wholesale acquisition cost as defined in United States Code, title
285.12 42, section 1395w-3a(c)(6)(B).

285.13 Subd. 3. **Prescription drug price increases reporting.** (a) Beginning July 1, 2020, a
285.14 drug manufacturer must submit to the commissioner the information described in paragraph
285.15 (b) for each prescription drug for which:

285.16 (1) the price was \$100 or greater for a 30-day supply or for a course of treatment lasting
285.17 less than 30 days; and

285.18 (2) there was a net increase of ten percent or greater in the price over the previous
285.19 12-month period.

285.20 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
285.21 the commissioner no later than 60 days after the price increase goes into effect, in the form
285.22 and manner prescribed by the commissioner, the following information:

285.23 (1) the name and price of the drug and the net increase, expressed as a percentage;

285.24 (2) the factors that contributed to the price increase;

285.25 (3) the name of any generic version of the prescription drug available on the market;

285.26 (4) the introductory price of the prescription drug when it was approved for marketing
285.27 by the Food and Drug Administration and the net yearly increase, by calendar year, in the
285.28 price of the prescription drug during the previous five years;

285.29 (5) the direct costs incurred by the manufacturer that are associated with the prescription
285.30 drug, listed separately:

285.31 (i) to manufacture the prescription drug;

- 286.1 (ii) to market the prescription drug, including advertising costs; and
- 286.2 (iii) to distribute the prescription drug;
- 286.3 (6) the total sales revenue for the prescription drug during the previous 12-month period;
- 286.4 (7) the manufacturer's net profit attributable to the prescription drug during the previous
- 286.5 12-month period;
- 286.6 (8) the total amount of financial assistance the manufacturer has provided through patient
- 286.7 prescription assistance programs, if applicable;
- 286.8 (9) any agreement between a manufacturer and another entity contingent upon any delay
- 286.9 in offering to market a generic version of the prescription drug;
- 286.10 (10) the patent expiration date of the prescription drug if it is under patent;
- 286.11 (11) the name and location of the company that manufactured the drug; and
- 286.12 (12) the ten highest prices paid for the prescription drug during the previous calendar
- 286.13 year in any country other than the United States.
- 286.14 (c) The manufacturer may submit any documentation necessary to support the information
- 286.15 reported under this subdivision.
- 286.16 Subd. 4. **New prescription drug price reporting.** (a) Beginning March 15, 2020, no
- 286.17 later than 60 days after a manufacturer introduces a new prescription drug for sale in the
- 286.18 United States that is a new brand name drug with a price that is greater than \$500 for a
- 286.19 30-day supply or a new generic drug with a price that is greater than \$200 for a 30-day
- 286.20 supply, the manufacturer must submit to the commissioner, in the form and manner prescribed
- 286.21 by the commissioner, the following information:
- 286.22 (1) the price of the prescription drug;
- 286.23 (2) whether the Food and Drug Administration granted the new prescription drug a
- 286.24 breakthrough therapy designation or a priority review;
- 286.25 (3) the direct costs incurred by the manufacturer that are associated with the prescription
- 286.26 drug, listed separately:
- 286.27 (i) to manufacture the prescription drug;
- 286.28 (ii) to market the prescription drug, including advertising costs; and
- 286.29 (iii) to distribute the prescription drug; and
- 286.30 (4) the patent expiration date of the drug if it is under patent.

287.1 (b) The manufacturer may submit documentation necessary to support the information
287.2 reported under this subdivision.

287.3 Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning July 1,
287.4 2020, for every newly acquired prescription drug for which the price increases by more
287.5 than \$100 for a 30-day supply from the price before the acquisition and the price after the
287.6 acquisition, the acquiring manufacturer must submit to the commissioner at least 60 days
287.7 after the acquiring manufacturer begins to sell the newly acquired prescription drug, in the
287.8 form and manner prescribed by the commissioner, the following information:

287.9 (1) the price of the prescription drug at the time of acquisition and in the calendar year
287.10 prior to acquisition;

287.11 (2) the name of the company from which the prescription drug was acquired, the date
287.12 acquired, and the purchase price;

287.13 (3) the year the prescription drug was introduced to market and the price of the
287.14 prescription drug at the time of introduction;

287.15 (4) the price of the prescription drug for the previous five years;

287.16 (5) any agreement between a manufacturer and another entity contingent upon any delay
287.17 in offering to market a generic version of the manufacturer's drug; and

287.18 (6) the patent expiration date of the drug if it is under patent.

287.19 (b) The manufacturer may submit any documentation necessary to support the information
287.20 reported under this subdivision.

287.21 Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner
287.22 shall post on the department's website, or may contract with a private entity or consortium
287.23 that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the
287.24 following information:

287.25 (1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the
287.26 manufacturers of those prescription drugs; and

287.27 (2) information reported to the commissioner under subdivisions 3, 4, and 5.

287.28 (b) The information must be published in an easy to read format and in a manner that
287.29 identifies the information that is disclosed on a per-drug basis and must not be aggregated
287.30 in a manner that prevents the identification of the prescription drug.

287.31 (c) The commissioner shall not post to the department's website or a private entity
287.32 contracting with the commissioner shall not post any information described in this section

288.1 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
288.2 information under section 13.37, subdivision 1, paragraph (b); or is information that is not
288.3 already available in the public domain.

288.4 (d) If the commissioner withholds any information from public disclosure pursuant to
288.5 this subdivision, the commissioner shall post to the department's website a report describing
288.6 the nature of the information and the commissioner's basis for withholding the information
288.7 from disclosure.

288.8 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
288.9 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of
288.10 Minnesota, or the commissioner of commerce, as appropriate; in issuing the form and format
288.11 of the information reported under this section; in posting information pursuant to subdivision
288.12 6; and in taking any other action for the purpose of implementing this section.

288.13 (b) The commissioner may consult with representatives of manufacturers to establish a
288.14 standard format for reporting information under this section to minimize administrative
288.15 burdens to the state and manufacturers.

288.16 Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil
288.17 penalty, as provided in paragraph (b), for:

288.18 (1) failing to submit timely reports or notices as required by this section;

288.19 (2) failing to provide information required under this section; or

288.20 (3) providing inaccurate or incomplete information under this section.

288.21 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000
288.22 per day of violation, based on the severity of each violation.

288.23 (c) The commissioner shall impose civil penalties under this section as provided in
288.24 section 144.99, subdivision 4.

288.25 (d) The commissioner may remit or mitigate civil penalties under this section upon terms
288.26 and conditions the commissioner considers proper and consistent with public health and
288.27 safety.

288.28 (e) Civil penalties collected under this section shall be deposited in the health care access
288.29 fund.

288.30 Subd. 9. **Legislative report.** (a) No later than January 15 of each year, beginning January
288.31 15, 2021, the commissioner shall report to the chairs and ranking minority members of the
288.32 legislative committees with jurisdiction over commerce and health and human services

289.1 policy and finance on the implementation of this section, including, but not limited to, the
289.2 effectiveness in addressing the following goals:

289.3 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

289.4 (2) enhancing the understanding on pharmaceutical spending trends; and

289.5 (3) assisting the state and other payers in the management of pharmaceutical costs.

289.6 (b) The report must include a summary of the information submitted to the commissioner
289.7 under subdivisions 3, 4, and 5.

289.8 Sec. 6. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

289.9 Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide
289.10 reconsideration requests, including the granting of variances, in accordance with the
289.11 procedures and criteria contained in chapter 245C. The commissioner must set aside a
289.12 disqualification for an individual who requests reconsideration and who meets the criteria
289.13 described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision
289.14 shall be provided to the individual and to the Department of Human Services. The
289.15 commissioner's decision to grant or deny a reconsideration of disqualification is the final
289.16 administrative agency action, except for the provisions under sections 245C.25, 245C.27,
289.17 and 245C.28, subdivision 3.

289.18 Sec. 7. Minnesota Statutes 2018, section 144.1506, subdivision 2, is amended to read:

289.19 Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary
289.20 care residency expansion grants to eligible primary care residency programs to plan and
289.21 implement new residency slots. A planning grant shall not exceed \$75,000, and a training
289.22 grant shall not exceed \$150,000 per new residency slot for the first year, \$100,000 for the
289.23 second year, and \$50,000 for the third year of the new residency slot. For eligible residency
289.24 programs longer than three years, training grants may be awarded for the duration of the
289.25 residency, not exceeding an average of \$100,000 per residency slot per year.

289.26 (b) Funds may be spent to cover the costs of:

289.27 (1) planning related to establishing an accredited primary care residency program;

289.28 (2) obtaining accreditation by the Accreditation Council for Graduate Medical Education
289.29 or another national body that accredits residency programs;

289.30 (3) establishing new residency programs or new resident training slots;

289.31 (4) recruitment, training, and retention of new residents and faculty;

- 290.1 (5) travel and lodging for new residents;
- 290.2 (6) faculty, new resident, and preceptor salaries related to new residency slots;
- 290.3 (7) training site improvements, fees, equipment, and supplies required for new primary
- 290.4 care resident training slots; and
- 290.5 (8) supporting clinical education in which trainees are part of a primary care team model.

290.6 Sec. 8. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

290.7 Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of

290.8 ~~\$6.36~~ \$9.72 for every service connection to a public water supply that is owned or operated

290.9 by a home rule charter city, a statutory city, a city of the first class, or a town. The

290.10 commissioner of health may also assess an annual fee for every service connection served

290.11 by a water user district defined in section 110A.02.

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

290.13 Sec. 9. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

290.14 (a) The commissioner of health shall administer, or contract for the administration of,

290.15 statewide tobacco cessation services to assist Minnesotans who are seeking advice or services

290.16 to help them quit using tobacco products. The commissioner shall establish statewide public

290.17 awareness activities to inform the public of the availability of the services and encourage

290.18 the public to utilize the services because of the dangers and harm of tobacco use and

290.19 dependence.

290.20 (b) Services to be provided may include, but are not limited to:

290.21 (1) telephone-based coaching and counseling;

290.22 (2) referrals;

290.23 (3) written materials mailed upon request;

290.24 (4) web-based texting or e-mail services; and

290.25 (5) free Food and Drug Administration-approved tobacco cessation medications.

290.26 (c) Services provided must be consistent with evidence-based best practices in tobacco

290.27 cessation services. Services provided must be coordinated with health plan company tobacco

290.28 prevention and cessation services that may be available to individuals depending on their

290.29 health coverage.

291.1 Sec. 10. Minnesota Statutes 2018, section 144.552, is amended to read:

291.2 **144.552 PUBLIC INTEREST REVIEW.**

291.3 (a) The following entities must submit a plan to the commissioner:

291.4 (1) a hospital seeking to increase its number of licensed beds; or

291.5 (2) an organization seeking to obtain a hospital license and notified by the commissioner
291.6 under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

291.7 The plan must include information that includes an explanation of how the expansion will
291.8 meet the public's interest. When submitting a plan to the commissioner, an applicant shall
291.9 pay the commissioner for the commissioner's cost of reviewing and monitoring the plan,
291.10 as determined by the commissioner and notwithstanding section 16A.1283. Money received
291.11 by the commissioner under this section is appropriated to the commissioner for the purpose
291.12 of administering this section. If the commissioner does not issue a finding within the time
291.13 limit specified in paragraph (c), the commissioner must return to the applicant the entire
291.14 amount the applicant paid to the commissioner. For a hospital that is seeking an exception
291.15 to the moratorium under section 144.551, the plan must be submitted to the commissioner
291.16 no later than August 1 of the calendar year prior to the year when the exception will be
291.17 considered by the legislature.

291.18 (b) Plans submitted under this section shall include detailed information necessary for
291.19 the commissioner to review the plan and reach a finding. The commissioner may request
291.20 additional information from the hospital submitting a plan under this section and from others
291.21 affected by the plan that the commissioner deems necessary to review the plan and make a
291.22 finding. If the commissioner determines that additional information is required from the
291.23 hospital submitting a plan under this section, the commissioner shall notify the hospital of
291.24 the additional information required no more than 30 days after the initial submission of the
291.25 plan. A hospital submitting a plan from whom the commissioner has requested additional
291.26 information shall submit the requested additional information within 14 calendar days of
291.27 the commissioner's request.

291.28 (c) The commissioner shall review the plan and, within ~~90~~ 150 calendar days, ~~but no~~
291.29 ~~more than six months if extenuating circumstances apply~~ of the initial submission of the
291.30 plan, issue a finding on whether the plan is in the public interest. In making the
291.31 recommendation, the commissioner shall consider issues including but not limited to:

291.32 (1) whether the new hospital or hospital beds are needed to provide timely access to care
291.33 or access to new or improved services given the number of available beds. For the purposes

292.1 of this clause, "available beds" means the number of licensed acute care beds that are
292.2 immediately available for use or could be brought online within 48 hours without significant
292.3 facility modifications;

292.4 (2) the financial impact of the new hospital or hospital beds on existing acute-care
292.5 hospitals that have emergency departments in the region;

292.6 (3) how the new hospital or hospital beds will affect the ability of existing hospitals in
292.7 the region to maintain existing staff;

292.8 (4) the extent to which the new hospital or hospital beds will provide services to
292.9 nonpaying or low-income patients relative to the level of services provided to these groups
292.10 by existing hospitals in the region; and

292.11 (5) the views of affected parties.

292.12 (d) If the plan is being submitted by an existing hospital seeking authority to construct
292.13 a new hospital, the commissioner shall also consider:

292.14 (1) the ability of the applicant to maintain the applicant's current level of community
292.15 benefit as defined in section 144.699, subdivision 5, at the existing facility; and

292.16 (2) the impact on the workforce at the existing facility including the applicant's plan for:

292.17 (i) transitioning current workers to the new facility;

292.18 (ii) retraining and employment security for current workers; and

292.19 (iii) addressing the impact of layoffs at the existing facility on affected workers.

292.20 (e) Prior to making a recommendation, the commissioner shall conduct a public hearing
292.21 in the affected hospital service area to take testimony from interested persons.

292.22 (f) Upon making a recommendation under paragraph (c), the commissioner shall provide
292.23 a copy of the recommendation to the chairs of the house of representatives and senate
292.24 committees having jurisdiction over health and human services policy and finance.

292.25 (g) If an exception to the moratorium is approved under section 144.551 after a review
292.26 under this section, the commissioner shall monitor the implementation of the exception up
292.27 to completion of the construction project. Thirty days after completion of the construction
292.28 project, the hospital shall submit to the commissioner a report on how the construction has
292.29 met the provisions of the plan originally submitted under the public interest review process
292.30 or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

293.1 Sec. 11. Minnesota Statutes 2018, section 144.586, is amended by adding a subdivision
293.2 to read:

293.3 Subd. 3. **Care coordination implementation.** (a) This subdivision applies to hospital
293.4 discharges involving a child with a high-cost medical or chronic condition who needs
293.5 post-hospital continuing aftercare, including but not limited to home health care services,
293.6 post-hospital extended care services, or outpatient services for follow-up or ancillary care,
293.7 or is at risk of recurrent hospitalization or emergency room services due to a medical or
293.8 chronic condition.

293.9 (b) In addition to complying with the discharge planning requirements in subdivision
293.10 2, the hospital must ensure that the following conditions are met and arrangements made
293.11 before discharging any patient described in paragraph (a):

293.12 (1) the patient's primary care provider and either the health carrier or, if the patient is
293.13 enrolled in medical assistance, the managed care organization are notified of the patient's
293.14 date of anticipated discharge and provided a description of the patient's aftercare needs and
293.15 a copy of the patient's discharge plan, including any necessary medical information release
293.16 forms;

293.17 (2) the appropriate arrangements for home health care or post-hospital extended care
293.18 services are made and the initial services as indicated on the discharge plan are scheduled;
293.19 and

293.20 (3) if the patient is eligible for care coordination services through a health plan or health
293.21 certified medical home, the appropriate care coordinator has connected with the patient's
293.22 family.

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

293.24 Sec. 12. [144.591] **DISCLOSURE OF HOSPITAL CHARGES.**

293.25 (a) Each hospital, including hospitals designated as critical access hospitals, shall provide
293.26 to each discharged patient within 30 calendar days of discharge an itemized description of
293.27 billed charges for medical services and goods the patient received during the hospital stay.
293.28 The itemized description of billed charges may include technical terms to describe the
293.29 medical services and goods if the technical terms are defined on the itemized description
293.30 with limited medical nomenclature. The itemized description of billed charges must not
293.31 describe a billed charge using only a medical billing code, "miscellaneous charges," or
293.32 "supply charges."

294.1 (b) A hospital may not bill or otherwise charge a patient for the itemized description of
 294.2 billed charges.

294.3 (c) A hospital must provide an itemized description by secure e-mail, via a secure online
 294.4 portal, or, upon request, by mail.

294.5 (d) This section does not apply to patients enrolled in Medicare, medical assistance, the
 294.6 MinnesotaCare program, or who receive health care coverage through an employer
 294.7 self-insured health plan.

294.8 **EFFECTIVE DATE.** This section is effective August 1, 2020.

294.9 Sec. 13. **[144.6502] ELECTRONIC MONITORING IN CERTAIN HEALTH CARE**
 294.10 **FACILITIES.**

294.11 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
 294.12 subdivision have the meanings given.

294.13 (b) "Electronic monitoring" means the placement and use of an electronic monitoring
 294.14 device by a resident in the resident's room or private living unit in accordance with this
 294.15 section.

294.16 (c) "Commissioner" means the commissioner of health.

294.17 (d) "Department" means the Department of Health.

294.18 (e) "Electronic monitoring device" means a camera or other device that captures, records,
 294.19 or broadcasts audio, video, or both, that is placed in a resident's room or private living unit
 294.20 and is used to monitor the resident or activities in the room or private living unit.

294.21 (f) "Facility" means a nursing home licensed under chapter 144A, a boarding care home
 294.22 licensed under sections 144.50 to 144.56, or a housing with services establishment registered
 294.23 under chapter 144D that is either subject to chapter 144G or has a disclosed special unit
 294.24 under section 325F.72.

294.25 (g) "Resident" means a person 18 years of age or older residing in a facility.

294.26 (h) "Resident representative" means one of the following in the order of priority listed,
 294.27 to the extent the person may reasonably be identified and located:

294.28 (1) a court-appointed guardian;

294.29 (2) a health care agent under section 145C.01, subdivision 2; or

295.1 (3) a person who is not an agent of a facility or of a home care provider designated in
295.2 writing by the resident and maintained in the resident's records on file with the facility or
295.3 with the resident's executed housing with services contract.

295.4 Subd. 2. **Electronic monitoring.** (a) A resident or a resident representative may conduct
295.5 electronic monitoring of the resident's room or private living unit through the use of electronic
295.6 monitoring devices placed in the resident's room or private living unit as provided in this
295.7 section.

295.8 (b) Nothing in this section precludes the use of electronic monitoring of health care
295.9 allowed under other law.

295.10 (c) Electronic monitoring authorized under this section is not a covered service under
295.11 home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and
295.12 256B.49.

295.13 (d) This section does not apply to monitoring technology authorized as a home and
295.14 community-based service under section 256B.0913, 256B.0915, 256B.092, or 256B.49.

295.15 Subd. 3. **Consent to electronic monitoring.** (a) Except as otherwise provided in this
295.16 subdivision, a resident must consent to electronic monitoring in the resident's room or private
295.17 living unit in writing on a notification and consent form. If the resident has not affirmatively
295.18 objected to electronic monitoring and the resident's medical professional determines that
295.19 the resident currently lacks the ability to understand and appreciate the nature and
295.20 consequences of electronic monitoring, the resident representative may consent on behalf
295.21 of the resident. For purposes of this subdivision, a resident affirmatively objects when the
295.22 resident orally, visually, or through the use of auxiliary aids or services declines electronic
295.23 monitoring. The resident's response must be documented on the notification and consent
295.24 form.

295.25 (b) Prior to a resident representative consenting on behalf of a resident, the resident must
295.26 be asked if the resident wants electronic monitoring to be conducted. The resident
295.27 representative must explain to the resident:

295.28 (1) the type of electronic monitoring device to be used;

295.29 (2) the standard conditions that may be placed on the electronic monitoring device's use,
295.30 including those listed in subdivision 6;

295.31 (3) with whom the recording may be shared under subdivision 10 or 11; and

295.32 (4) the resident's ability to decline all recording.

296.1 (c) A resident, or resident representative when consenting on behalf of the resident, may
296.2 consent to electronic monitoring with any conditions of the resident's or resident
296.3 representative's choosing, including the list of standard conditions provided in subdivision
296.4 6. A resident, or resident representative when consenting on behalf of the resident, may
296.5 request that the electronic monitoring device be turned off or the visual or audio recording
296.6 component of the electronic monitoring device be blocked at any time.

296.7 (d) Prior to implementing electronic monitoring, a resident, or resident representative
296.8 when acting on behalf of the resident, must obtain the written consent on the notification
296.9 and consent form of any other resident residing in the shared room or shared private living
296.10 unit. A roommate's or roommate's resident representative's written consent must comply
296.11 with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's
296.12 resident representative under this paragraph authorizes the resident's use of any recording
296.13 obtained under this section, as provided under subdivision 10 or 11.

296.14 (e) Any resident conducting electronic monitoring must immediately remove or disable
296.15 an electronic monitoring device prior to a new roommate moving into a shared room or
296.16 shared private living unit, unless the resident obtains the roommate's or roommate's resident
296.17 representative's written consent as provided under paragraph (d) prior to the roommate
296.18 moving into the shared room or shared private living unit. Upon obtaining the new
296.19 roommate's signed notification and consent form and submitting the form to the facility as
296.20 required under subdivision 5, the resident may resume electronic monitoring.

296.21 (f) The resident or roommate, or the resident representative or roommate's resident
296.22 representative if the representative is consenting on behalf of the resident or roommate, may
296.23 withdraw consent at any time and the withdrawal of consent must be documented on the
296.24 original consent form as provided under subdivision 5, paragraph (c).

296.25 Subd. 4. **Refusal of roommate to consent.** If a resident of a facility who is residing in
296.26 a shared room or shared living unit, or the resident representative of such a resident when
296.27 acting on behalf of the resident, wants to conduct electronic monitoring and another resident
296.28 living in or moving into the same shared room or shared living unit refuses to consent to
296.29 the use of an electronic monitoring device, the facility shall make a reasonable attempt to
296.30 accommodate the resident who wants to conduct electronic monitoring. A facility has met
296.31 the requirement to make a reasonable attempt to accommodate a resident or resident
296.32 representative who wants to conduct electronic monitoring when, upon notification that a
296.33 roommate has not consented to the use of an electronic monitoring device in the resident's
296.34 room, the facility offers to move the resident to another shared room or shared living unit
296.35 that is available at the time of the request. If a resident chooses to reside in a private room

297.1 or private living unit in a facility in order to accommodate the use of an electronic monitoring
297.2 device, the resident must pay either the private room rate in a nursing home setting, or the
297.3 applicable rent in a housing with services establishment. If a facility is unable to
297.4 accommodate a resident due to lack of space, the facility must reevaluate the request every
297.5 two weeks until the request is fulfilled. A facility is not required to provide a private room,
297.6 a single-bed room, or a private living unit to a resident who is unable to pay.

297.7 Subd. 5. **Notice to facility.** (a) Electronic monitoring may begin only after the resident
297.8 or resident representative who intends to place an electronic monitoring device and any
297.9 roommate or roommate's resident representative completes the notification and consent
297.10 form and submits the form to the facility.

297.11 (b) Upon receipt of any completed notification and consent form, the facility must place
297.12 the original form in the resident's file or file the original form with the resident's housing
297.13 with services contract. The facility must provide a copy to the resident and the resident's
297.14 roommate, if applicable.

297.15 (c) In the event that a resident or roommate, or the resident representative or roommate's
297.16 resident representative if the representative is consenting on behalf of the resident or
297.17 roommate, chooses to alter the conditions under which consent to electronic monitoring is
297.18 given or chooses to withdraw consent to electronic monitoring, the facility must make
297.19 available the original notification and consent form so that it may be updated. Upon receipt
297.20 of the updated form, the facility must place the updated form in the resident's file or file the
297.21 original form with the resident's signed housing with services contract. The facility must
297.22 provide a copy of the updated form to the resident and the resident's roommate, if applicable.

297.23 (d) If a new roommate, or the new roommate's resident representative when consenting
297.24 on behalf of the new roommate, does not submit to the facility a completed notification and
297.25 consent form and the resident conducting the electronic monitoring does not remove or
297.26 disable the electronic monitoring device, the facility must remove the electronic monitoring
297.27 device.

297.28 (e) If a roommate, or the roommate's resident representative when withdrawing consent
297.29 on behalf of the roommate, submits an updated notification and consent form withdrawing
297.30 consent and the resident conducting electronic monitoring does not remove or disable the
297.31 electronic monitoring device, the facility must remove the electronic monitoring device.

297.32 (f) Notwithstanding paragraph (a), the resident or resident representative who intends
297.33 to place an electronic monitoring device may do so without submitting a notification and
297.34 consent form to the facility, provided that:

298.1 (1) the resident or resident representative reasonably fears retaliation by the facility;

298.2 (2) the resident does not have a roommate;

298.3 (3) the resident or resident representative submits the completed notification and consent
298.4 form to the Office of the Ombudsman for Long-Term Care;

298.5 (4) the resident or resident representative submits the notification and consent form to
298.6 the facility within seven calendar days of placing the electronic monitoring device; and

298.7 (5) the resident or resident representative immediately submits a Minnesota Adult Abuse
298.8 Reporting Center report or police report upon evidence from the electronic monitoring
298.9 device that suspected maltreatment has occurred between the time the electronic monitoring
298.10 device is placed under this paragraph and the time the resident or resident representative
298.11 submits the completed notification and consent form to the facility.

298.12 Subd. 6. **Form requirements.** (a) The notification and consent form completed by the
298.13 resident must include, at a minimum, the following information:

298.14 (1) the resident's signed consent to electronic monitoring or the signature of the resident
298.15 representative, if applicable. If a person other than the resident signs the consent form, the
298.16 form must document the following:

298.17 (i) the date the resident was asked if the resident wants electronic monitoring to be
298.18 conducted;

298.19 (ii) who was present when the resident was asked;

298.20 (iii) an acknowledgment that the resident did not affirmatively object; and

298.21 (iv) the source of authority allowing the resident representative to sign the notification
298.22 and consent form on the resident's behalf;

298.23 (2) the resident's roommate's signed consent or the signature of the roommate's resident
298.24 representative, if applicable. If a roommate's resident representative signs the consent form,
298.25 the form must document the following:

298.26 (i) the date the roommate was asked if the roommate wants electronic monitoring to be
298.27 conducted;

298.28 (ii) who was present when the roommate was asked;

298.29 (iii) an acknowledgment that the roommate did not affirmatively object; and

298.30 (iv) the source of authority allowing the resident representative to sign the notification
298.31 and consent form on the resident's behalf;

- 299.1 (3) the type of electronic monitoring device to be used;
- 299.2 (4) a list of standard conditions or restrictions that the resident or a roommate may elect
- 299.3 to place on the use of the electronic monitoring device, including but not limited to:
- 299.4 (i) prohibiting audio recording;
- 299.5 (ii) prohibiting video recording;
- 299.6 (iii) prohibiting broadcasting of audio or video;
- 299.7 (iv) turning off the electronic monitoring device or blocking the visual recording
- 299.8 component of the electronic monitoring device for the duration of an exam or procedure by
- 299.9 a health care professional;
- 299.10 (v) turning off the electronic monitoring device or blocking the visual recording
- 299.11 component of the electronic monitoring device while dressing or bathing is performed; and
- 299.12 (vi) turning off the electronic monitoring device for the duration of a visit with a spiritual
- 299.13 adviser, ombudsman, attorney, financial planner, intimate partner, or other visitor;
- 299.14 (5) any other condition or restriction elected by the resident or roommate on the use of
- 299.15 an electronic monitoring device;
- 299.16 (6) a statement of the circumstances under which a recording may be disseminated under
- 299.17 subdivision 10;
- 299.18 (7) a signature box for documenting that the resident or roommate has withdrawn consent;
- 299.19 and
- 299.20 (8) an acknowledgment that the resident, in accordance with subdivision 3, consents,
- 299.21 authorizes, and allows the Office of Ombudsman for Long-Term Care and representatives
- 299.22 of its office to disclose information about the form limited to:
- 299.23 (i) the fact that the form was received from the resident or resident representative;
- 299.24 (ii) if signed by a resident representative, the name of the resident representative and
- 299.25 the source of authority allowing the resident representative to sign the notification and
- 299.26 consent form on the resident's behalf; and
- 299.27 (iii) the type of electronic monitoring device placed.
- 299.28 (b) Facilities must make the notification and consent form available to the residents and
- 299.29 inform residents of their option to conduct electronic monitoring of their rooms or private
- 299.30 living unit.

300.1 (c) Notification and consent forms received by the Office of Ombudsman for Long-Term
300.2 Care are data protected under section 256.9744.

300.3 Subd. 7. **Cost and installation.** (a) A resident choosing to conduct electronic monitoring
300.4 must do so at the resident's own expense, including paying purchase, installation,
300.5 maintenance, and removal costs.

300.6 (b) If a resident chooses to place an electronic monitoring device that uses Internet
300.7 technology for visual or audio monitoring, the resident may be responsible for contracting
300.8 with an Internet service provider.

300.9 (c) The facility shall make a reasonable attempt to accommodate the resident's installation
300.10 needs, including allowing access to the facility's public-use Internet or Wi-Fi systems when
300.11 available for other public uses.

300.12 (d) All electronic monitoring device installations and supporting services must be
300.13 UL-listed.

300.14 Subd. 8. **Notice to visitors.** (a) A facility shall post a sign at each facility entrance
300.15 accessible to visitors that states "Security cameras and audio devices may be present to
300.16 record persons and activities."

300.17 (b) The facility is responsible for installing and maintaining the signage required in this
300.18 subdivision.

300.19 Subd. 9. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly
300.20 hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a
300.21 resident's room or private living unit without the permission of the resident or resident
300.22 representative.

300.23 (b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring
300.24 device or blocks the visual recording component of the electronic monitoring device at the
300.25 direction of the resident or resident representative, or if consent has been withdrawn.

300.26 Subd. 10. **Dissemination of recordings.** (a) No person may access any video or audio
300.27 recording created through authorized electronic monitoring without the written consent of
300.28 the resident or resident representative.

300.29 (b) Except as required under other law, a recording or copy of a recording made as
300.30 provided in this section may only be disseminated for the purpose of addressing health,
300.31 safety, or welfare concerns of a resident or residents.

301.1 (c) A person disseminating a recording or copy of a recording made as provided in this
301.2 section in violation of paragraph (b) may be civilly or criminally liable.

301.3 Subd. 11. **Admissibility of evidence.** Subject to applicable rules of evidence and
301.4 procedure, any video or audio recording created through electronic monitoring under this
301.5 section may be admitted into evidence in a civil, criminal, or administrative proceeding.

301.6 Subd. 12. **Liability.** (a) For the purposes of state law, the mere presence of an electronic
301.7 monitoring device in a resident's room or private living unit is not a violation of the resident's
301.8 right to privacy under section 144.651 or 144A.44.

301.9 (b) For the purposes of state law, a facility or home care provider is not civilly or
301.10 criminally liable for the mere disclosure by a resident or a resident representative of a
301.11 recording.

301.12 Subd. 13. **Immunity from liability.** The Office of Ombudsman for Long-Term Care
301.13 and representatives of the office are immune from liability as provided under section
301.14 256.9742, subdivision 2.

301.15 Subd. 14. **Resident protections.** (a) A facility must not:

301.16 (1) refuse to admit a potential resident or remove a resident because the facility disagrees
301.17 with the potential resident's or the resident's decisions regarding electronic monitoring,
301.18 including when the decision is made by a resident representative acting on behalf of the
301.19 resident;

301.20 (2) retaliate or discriminate against any resident for consenting or refusing to consent
301.21 to electronic monitoring; or

301.22 (3) prevent the placement or use of an electronic monitoring device by a resident who
301.23 has provided the facility or the Office of the Ombudsman for Long-Term Care with notice
301.24 and consent as required under this section.

301.25 (b) Any contractual provision prohibiting, limiting, or otherwise modifying the rights
301.26 and obligations in this section is contrary to public policy and is void and unenforceable.

301.27 Subd. 15. **Employee discipline.** An employee of the facility or of a contractor providing
301.28 services at the facility, including an arranged home care provider as defined in section
301.29 144D.01, subdivision 2a, who is the subject of proposed corrective or disciplinary action
301.30 based upon evidence obtained by electronic monitoring must be given access to that evidence
301.31 for purposes of defending against the proposed action. The recording or a copy of the
301.32 recording must be treated confidentially by the employee and must not be further
301.33 disseminated to any other person except as required under law. Any copy of the recording

302.1 must be returned to the facility or resident who provided the copy when it is no longer
302.2 needed for purposes of defending against a proposed action.

302.3 Subd. 16. **Penalties.** (a) The commissioner may issue a correction order as provided
302.4 under section 144A.10, 144A.45, or 144A.474, upon a finding that the facility has failed to
302.5 comply with subdivision 5, paragraphs (b) to (e); 6, paragraph (b); 7, paragraph (c); 8; 9;
302.6 10; or 14. For each violation of this section, the commissioner may impose a fine up to \$500
302.7 upon a finding of noncompliance with a correction order issued according to this subdivision.

302.8 (b) The commissioner may exercise the commissioner's authority provided under section
302.9 144D.05 to compel a housing with services establishment to meet the requirements of this
302.10 section.

302.11 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to all
302.12 agreements in effect, entered into, or renewed on or after that date.

302.13 Sec. 14. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

302.14 **Subd. 2. Newborn Hearing Screening Advisory Committee.** (a) The commissioner
302.15 of health shall establish a Newborn Hearing Screening Advisory Committee to advise and
302.16 assist the Department of Health and the Department of Education in:

302.17 (1) developing protocols and timelines for screening, rescreening, and diagnostic
302.18 audiological assessment and early medical, audiological, and educational intervention
302.19 services for children who are deaf or hard-of-hearing;

302.20 (2) designing protocols for tracking children from birth through age three that may have
302.21 passed newborn screening but are at risk for delayed or late onset of permanent hearing
302.22 loss;

302.23 (3) designing a technical assistance program to support facilities implementing the
302.24 screening program and facilities conducting rescreening and diagnostic audiological
302.25 assessment;

302.26 (4) designing implementation and evaluation of a system of follow-up and tracking; and

302.27 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
302.28 culturally appropriate services for children with a confirmed hearing loss and their families.

302.29 (b) The commissioner of health shall appoint at least one member from each of the
302.30 following groups with no less than two of the members being deaf or hard-of-hearing:

302.31 (1) a representative from a consumer organization representing culturally deaf persons;

- 303.1 (2) a parent with a child with hearing loss representing a parent organization;
- 303.2 (3) a consumer from an organization representing oral communication options;
- 303.3 (4) a consumer from an organization representing cued speech communication options;
- 303.4 (5) an audiologist who has experience in evaluation and intervention of infants and
303.5 young children;
- 303.6 (6) a speech-language pathologist who has experience in evaluation and intervention of
303.7 infants and young children;
- 303.8 (7) two primary care providers who have experience in the care of infants and young
303.9 children, one of which shall be a pediatrician;
- 303.10 (8) a representative from the early hearing detection intervention teams;
- 303.11 (9) a representative from the Department of Education resource center for the deaf and
303.12 hard-of-hearing or the representative's designee;
- 303.13 (10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;
- 303.14 (11) a representative from the Department of Human Services Deaf and Hard-of-Hearing
303.15 Services Division;
- 303.16 (12) one or more of the Part C coordinators from the Department of Education, the
303.17 Department of Health, or the Department of Human Services or the department's designees;
- 303.18 (13) the Department of Health early hearing detection and intervention coordinators;
- 303.19 (14) two birth hospital representatives from one rural and one urban hospital;
- 303.20 (15) a pediatric geneticist;
- 303.21 (16) an otolaryngologist;
- 303.22 (17) a representative from the Newborn Screening Advisory Committee under this
303.23 subdivision; and
- 303.24 (18) a representative of the Department of Education regional low-incidence facilitators.
- 303.25 The commissioner must complete the appointments required under this subdivision by
303.26 September 1, 2007.
- 303.27 (c) The Department of Health member shall chair the first meeting of the committee. At
303.28 the first meeting, the committee shall elect a chair from its membership. The committee
303.29 shall meet at the call of the chair, at least four times a year. The committee shall adopt
303.30 written bylaws to govern its activities. The Department of Health shall provide technical

304.1 and administrative support services as required by the committee. These services shall
 304.2 include technical support from individuals qualified to administer infant hearing screening,
 304.3 rescreening, and diagnostic audiological assessments.

304.4 Members of the committee shall receive no compensation for their service, but shall be
 304.5 reimbursed as provided in section 15.059 for expenses incurred as a result of their duties
 304.6 as members of the committee.

304.7 (d) By February 15, 2015, and by February 15 of the odd-numbered years after that date,
 304.8 the commissioner shall report to the chairs and ranking minority members of the legislative
 304.9 committees with jurisdiction over health and data privacy on the activities of the committee
 304.10 that have occurred during the past two years.

304.11 (e) This subdivision expires June 30, ~~2019~~ 2025.

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

304.13 Sec. 15. Minnesota Statutes 2018, section 144H.01, subdivision 5, is amended to read:

304.14 Subd. 5. **Medically complex or technologically dependent child.** "Medically complex
 304.15 or technologically dependent child" means a child under ~~21~~ seven years of age who, because
 304.16 of a medical condition, requires continuous therapeutic interventions or skilled nursing
 304.17 supervision ~~which~~ that must be prescribed by a licensed physician and administered by, or
 304.18 under the direct supervision of, a licensed registered nurse.

304.19 Sec. 16. Minnesota Statutes 2018, section 144H.04, subdivision 1, is amended to read:

304.20 Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a
 304.21 completed application for licensure to the commissioner, in a form and manner determined
 304.22 by the commissioner. The applicant must also submit the application fee, in the amount
 304.23 specified in section 144H.05, subdivision 1. ~~Effective January 1, 2018,~~ Beginning July 1,
 304.24 2020, the commissioner shall issue a license for a PPEC center if the commissioner
 304.25 determines that the applicant and center meet the requirements of this chapter and rules that
 304.26 apply to PPEC centers. A license issued under this subdivision is valid for two years.

304.27 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2018.

304.28 Sec. 17. Minnesota Statutes 2018, section 144H.04, is amended by adding a subdivision
 304.29 to read:

304.30 **Subd. 1a. Licensure phase-in.** (a) The commissioner shall phase in licensure of PPEC
 304.31 centers by issuing prior to June 30, 2024, no more than two licenses to applicants the

305.1 commissioner determines meet the requirements of this chapter. A license issued under this
 305.2 subdivision is valid until June 30, 2024.

305.3 (b) This subdivision expires July 1, 2024.

305.4 **EFFECTIVE DATE.** This section is effective upon the effective date of section 12.

305.5 Sec. 18. Minnesota Statutes 2018, section 144H.06, is amended to read:

305.6 **144H.06 APPLICATION OF RULES FOR HOSPICE SERVICES AND**
 305.7 **RESIDENTIAL HOSPICE FACILITIES.**

305.8 Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter,
 305.9 except that the following parts, subparts, and items, ~~and subitems~~ do not apply:

305.10 (1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

305.11 (2) Minnesota Rules, part 4664.0008;

305.12 (3) Minnesota Rules, part 4664.0010, subparts 3; 4, ~~items A, subitem (6), and item B;~~
 305.13 and 8;

305.14 (4) Minnesota Rules, part 4664.0020, subpart 13;

305.15 (5) Minnesota Rules, part 4664.0370, subpart 1;

305.16 (6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

305.17 (7) Minnesota Rules, part 4664.0420;

305.18 (8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

305.19 (9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

305.20 (10) Minnesota Rules, part 4664.0490; and

305.21 (11) Minnesota Rules, part 4664.0520.

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

305.23 Sec. 19. Minnesota Statutes 2018, section 144H.07, subdivision 1, is amended to read:

305.24 Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex
 305.25 or technologically dependent children, based on a protocol of care established for each child.
 305.26 A PPEC center may provide services up to ~~14~~ 12.5 hours a day and up to six days a week
 305.27 with hours of operation during normal waking hours.

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

306.1 Sec. 20. Minnesota Statutes 2018, section 144H.07, subdivision 2, is amended to read:

306.2 Subd. 2. **Limitations.** A PPEC center must comply with the following standards related
306.3 to services:

306.4 (1) a child is prohibited from attending a PPEC center for more than ~~14~~ 12.5 hours within
306.5 a 24-hour period;

306.6 (2) a PPEC center is prohibited from providing services other than those provided to
306.7 medically complex or technologically dependent children; and

306.8 (3) the maximum capacity for medically complex or technologically dependent children
306.9 at a center shall not exceed 45 children.

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

306.11 Sec. 21. Minnesota Statutes 2018, section 144H.08, subdivision 2, is amended to read:

306.12 Subd. 2. ~~Duties of administrator~~ **Administrators.** (a) The center administrator is
306.13 responsible and accountable for overall management of the center. The administrator must:

306.14 (1) designate in writing a person to be responsible for the center when the administrator
306.15 is absent from the center for more than 24 hours;

306.16 (2) maintain the following written records, in a place and form and using a system that
306.17 allows for inspection of the records by the commissioner during normal business hours:

306.18 (i) a daily census record, which indicates the number of children currently receiving
306.19 services at the center;

306.20 (ii) a record of all accidents or unusual incidents involving any child or staff member
306.21 that caused, or had the potential to cause, injury or harm to a person at the center or to center
306.22 property;

306.23 (iii) copies of all current agreements with providers of supportive services or contracted
306.24 services;

306.25 (iv) copies of all current agreements with consultants employed by the center,
306.26 documentation of each consultant's visits, and written, dated reports; and

306.27 (v) a personnel record for each employee, which must include an application for
306.28 employment, references, employment history for the preceding five years, and copies of all
306.29 performance evaluations;

306.30 (3) develop and maintain a current job description for each employee;

307.1 (4) provide necessary qualified personnel and ancillary services to ensure the health,
307.2 safety, and proper care for each child; and

307.3 (5) develop and implement infection control policies that comply with rules adopted by
307.4 the commissioner regarding infection control.

307.5 (b) In order to serve as an administrator of a PPEC center, an individual must have at
307.6 least two years of experience in the past five years caring for or managing the care of
307.7 medically complex or technologically dependent individuals.

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

307.9 Sec. 22. Minnesota Statutes 2018, section 144H.11, subdivision 2, is amended to read:

307.10 Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a
307.11 registered nurse licensed in Minnesota, and hold a current certification in cardiopulmonary
307.12 resuscitation, ~~and have experience in the previous 24 months in being responsible for the~~
307.13 ~~care of acutely ill or chronically ill children.~~

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

307.15 Sec. 23. Minnesota Statutes 2018, section 144H.11, subdivision 3, is amended to read:

307.16 Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC
307.17 center must be supervised by a registered nurse and must be a licensed practical nurse
307.18 licensed in Minnesota, ~~have at least two years of experience in pediatrics,~~ and hold a current
307.19 certification in cardiopulmonary resuscitation.

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

307.21 Sec. 24. Minnesota Statutes 2018, section 144H.11, subdivision 4, is amended to read:

307.22 Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this
307.23 subdivision may include nursing assistants ~~and~~ or individuals with training and experience
307.24 in the field of education, social services, or child care.

307.25 (b) All direct care personnel employed by a PPEC center must work under the supervision
307.26 of a registered nurse and are responsible for providing direct care to children at the center.
307.27 Direct care personnel must have extensive, documented education and skills training in
307.28 providing care to infants and toddlers, provide employment references documenting skill
307.29 in the care of infants and children, and hold a current certification in cardiopulmonary
307.30 resuscitation.

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

308.2 Sec. 25. Minnesota Statutes 2018, section 145.4131, subdivision 1, is amended to read:

308.3 Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare
308.4 a reporting form for use by physicians or facilities performing abortions. A copy of this
308.5 section shall be attached to the form. A physician or facility performing an abortion shall
308.6 obtain a form from the commissioner.

308.7 (b) The form shall require the following information:

308.8 (1) the number of abortions performed by the physician in the previous calendar year,
308.9 reported by month;

308.10 (2) the method used for each abortion;

308.11 (3) the approximate gestational age expressed in one of the following increments:

308.12 (i) less than nine weeks;

308.13 (ii) nine to ten weeks;

308.14 (iii) 11 to 12 weeks;

308.15 (iv) 13 to 15 weeks;

308.16 (v) 16 to 20 weeks;

308.17 (vi) 21 to 24 weeks;

308.18 (vii) 25 to 30 weeks;

308.19 (viii) 31 to 36 weeks; or

308.20 (ix) 37 weeks to term;

308.21 (4) the age of the woman at the time the abortion was performed;

308.22 (5) the specific reason for the abortion, including, but not limited to, the following:

308.23 (i) the pregnancy was a result of rape;

308.24 (ii) the pregnancy was a result of incest;

308.25 (iii) economic reasons;

308.26 (iv) the woman does not want children at this time;

308.27 (v) the woman's emotional health is at stake;

308.28 (vi) the woman's physical health is at stake;

- 309.1 (vii) the woman will suffer substantial and irreversible impairment of a major bodily
 309.2 function if the pregnancy continues;
- 309.3 (viii) the pregnancy resulted in fetal anomalies; or
- 309.4 (ix) unknown or the woman refused to answer;
- 309.5 (6) the number of prior induced abortions;
- 309.6 (7) the number of prior spontaneous abortions;
- 309.7 (8) whether the abortion was paid for by:
- 309.8 (i) private coverage;
- 309.9 (ii) public assistance health coverage; or
- 309.10 (iii) self-pay;
- 309.11 (9) whether coverage was under:
- 309.12 (i) a fee-for-service plan;
- 309.13 (ii) a capitated private plan; or
- 309.14 (iii) other;
- 309.15 (10) complications, if any, for each abortion and for the aftermath of each abortion.
 309.16 Space for a description of any complications shall be available on the form;
- 309.17 (11) the medical specialty of the physician performing the abortion;
- 309.18 (12) if the abortion was performed via telemedicine, the facility code for the patient and
 309.19 the facility code for the physician; ~~and~~
- 309.20 (13) whether the abortion resulted in a born alive infant, as defined in section 145.423,
 309.21 subdivision 4, and:
- 309.22 (i) any medical actions taken to preserve the life of the born alive infant;
- 309.23 (ii) whether the born alive infant survived; and
- 309.24 (iii) the status of the born alive infant, should the infant survive, if known;₂
- 309.25 (14) whether a determination of probable postfertilization age was made and the probable
 309.26 postfertilization age determined, including:
- 309.27 (i) the method used to make such a determination; or
- 309.28 (ii) if a determination was not made prior to performing an abortion, the basis of the
 309.29 determination that a medical emergency existed; and

310.1 (15) for abortions performed after a determination of postfertilization age of 20 or more
310.2 weeks, the basis of the determination that the pregnant woman had a condition that so
310.3 complicated her medical condition as to necessitate the abortion of her pregnancy to avert
310.4 her death or to avert serious risk of substantial and irreversible physical impairment of a
310.5 major bodily function, not including psychological or emotional conditions.

310.6 Sec. 26. [145.4141] DEFINITIONS.

310.7 Subdivision 1. **Scope.** For purposes of sections 145.4141 to 145.4147, the following
310.8 terms have the meanings given them.

310.9 Subd. 2. **Abortion.** "Abortion" means the use or prescription of any instrument, medicine,
310.10 drug, or any other substance or device to terminate the pregnancy of a woman known to be
310.11 pregnant, with an intention other than to increase the probability of a live birth; to preserve
310.12 the life or health of the child after live birth; or to remove a dead unborn child who died as
310.13 the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant
310.14 woman or her unborn child; and which causes the premature termination of the pregnancy.

310.15 Subd. 3. **Attempt to perform or induce an abortion.** "Attempt to perform or induce
310.16 an abortion" means an act, or an omission of a statutorily required act, that, under the
310.17 circumstances as the actor believes them to be, constitutes a substantial step in a course of
310.18 conduct planned to culminate in the performance or induction of an abortion in this state in
310.19 violation of sections 145.4141 to 145.4147.

310.20 Subd. 4. **Fertilization.** "Fertilization" means the fusion of a human spermatozoon with
310.21 a human ovum.

310.22 Subd. 5. **Medical emergency.** "Medical emergency" means a condition that, in reasonable
310.23 medical judgment, so complicates the medical condition of the pregnant woman that it
310.24 necessitates the immediate abortion of her pregnancy without first determining
310.25 postfertilization age to avert her death or for which the delay necessary to determine
310.26 postfertilization age will create serious risk of substantial and irreversible physical impairment
310.27 of a major bodily function not including psychological or emotional conditions. No condition
310.28 shall be deemed a medical emergency if based on a claim or diagnosis that the woman will
310.29 engage in conduct which she intends to result in her death or in substantial and irreversible
310.30 physical impairment of a major bodily function.

310.31 Subd. 6. **Physician.** "Physician" means any person licensed to practice medicine and
310.32 surgery or osteopathic medicine and surgery in this state.

311.1 Subd. 7. **Postfertilization age.** "Postfertilization age" means the age of the unborn child
311.2 as calculated from the fusion of a human spermatozoon with a human ovum.

311.3 Subd. 8. **Probable postfertilization age of the unborn child.** "Probable postfertilization
311.4 age of the unborn child" means what, in reasonable medical judgment, will with reasonable
311.5 probability be the postfertilization age of the unborn child at the time the abortion is planned
311.6 to be performed or induced.

311.7 Subd. 9. **Reasonable medical judgment.** "Reasonable medical judgment" means a
311.8 medical judgment that would be made by a reasonably prudent physician knowledgeable
311.9 about the case and the treatment possibilities with respect to the medical conditions involved.

311.10 Subd. 10. **Unborn child or fetus.** "Unborn child" or "fetus" means an individual organism
311.11 of the species homo sapiens from fertilization until live birth.

311.12 Subd. 11. **Woman.** "Woman" means a female human being whether or not she has
311.13 reached the age of majority.

311.14 Sec. 27. **[145.4142] LEGISLATIVE FINDINGS.**

311.15 (a) The legislature makes the following findings.

311.16 (b) Pain receptors (nociceptors) are present throughout an unborn child's entire body
311.17 and nerves link these receptors to the brain's thalamus and subcortical plate by 20 weeks.

311.18 (c) By eight weeks after fertilization, an unborn child reacts to touch. After 20 weeks
311.19 an unborn child reacts to stimuli that would be recognized as painful if applied to an adult
311.20 human, for example by recoiling.

311.21 (d) In the unborn child, application of such painful stimuli is associated with significant
311.22 increases in stress hormones known as the stress response.

311.23 (e) Subjection to such painful stimuli is associated with long-term harmful
311.24 neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional,
311.25 behavioral, and learning disabilities later in life.

311.26 (f) For the purposes of surgery on an unborn child, fetal anesthesia is routinely
311.27 administered and is associated with a decrease in stress hormones compared to the level
311.28 when painful stimuli is applied without anesthesia.

311.29 (g) The position, asserted by some medical experts, that an unborn child is incapable of
311.30 experiencing pain until a point later in pregnancy than 20 weeks after fertilization
311.31 predominately rests on the assumption that the ability to experience pain depends on the
311.32 cerebral cortex and requires nerve connections between the thalamus and the cortex.

312.1 However, recent medical research and analysis, especially since 2007, provides strong
312.2 evidence for the conclusion that a functioning cortex is not necessary to experience pain.

312.3 (h) Substantial evidence indicates that children born missing the bulk of the cerebral
312.4 cortex, those with hydranencephaly, nevertheless experience pain.

312.5 (i) In adults, stimulation or ablation of the cerebral cortex does not alter pain perception,
312.6 while stimulation or ablation of the thalamus does.

312.7 (j) Substantial evidence indicates that structures used for pain processing in early
312.8 development differ from those of adults, using different neural elements available at specific
312.9 times during development, such as the subcortical plate, to fulfill the role of pain processing.

312.10 (k) The position asserted by some medical experts, that the unborn child remains in a
312.11 coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with
312.12 the documented reaction of unborn children to painful stimuli and with the experience of
312.13 fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to
312.14 prevent the unborn child from thrashing about in reaction to invasive surgery.

312.15 (l) Consequently, there is substantial medical evidence that an unborn child is capable
312.16 of experiencing pain by 20 weeks after fertilization.

312.17 (m) It is the purpose of the state to assert a compelling state interest in protecting the
312.18 lives of unborn children from the stage at which substantial medical evidence indicates that
312.19 they are capable of feeling pain.

312.20 Sec. 28. **[145.4143] DETERMINATION OF POSTFERTILIZATION AGE.**

312.21 Subdivision 1. **Determination of postfertilization age.** Except in the case of a medical
312.22 emergency, no abortion shall be performed or induced or be attempted to be performed or
312.23 induced unless the physician performing or inducing it has first made a determination of
312.24 the probable postfertilization age of the unborn child or relied upon such a determination
312.25 made by another physician. In making such a determination, the physician shall make those
312.26 inquiries of the woman and perform or cause to be performed those medical examinations
312.27 and tests that a reasonably prudent physician, knowledgeable about the case and the medical
312.28 conditions involved, would consider necessary to perform in making an accurate diagnosis
312.29 with respect to postfertilization age.

312.30 Subd. 2. **Unprofessional conduct.** Failure by any physician to conform to any
312.31 requirement of this section constitutes unprofessional conduct under section 147.091,
312.32 subdivision 1, paragraph (k).

313.1 Sec. 29. **[145.4144] ABORTION OF UNBORN CHILD OF 20 OR MORE WEEKS**
 313.2 **POSTFERTILIZATION AGE PROHIBITED; CAPABLE OF FEELING PAIN.**

313.3 **Subdivision 1. Abortion prohibition; exemption.** No person shall perform or induce
 313.4 or attempt to perform or induce an abortion upon a woman when it has been determined,
 313.5 by the physician performing or inducing or attempting to perform or induce the abortion,
 313.6 or by another physician upon whose determination that physician relies, that the probable
 313.7 postfertilization age of the woman's unborn child is 20 or more weeks unless, in reasonable
 313.8 medical judgment, she has a condition which so complicates her medical condition as to
 313.9 necessitate the abortion of her pregnancy to avert her death or to avert serious risk of
 313.10 substantial and irreversible physical impairment of a major bodily function, not including
 313.11 psychological or emotional conditions. No such condition shall be deemed to exist if it is
 313.12 based on a claim or diagnosis that the woman will engage in conduct which she intends to
 313.13 result in her death or in substantial and irreversible physical impairment of a major bodily
 313.14 function.

313.15 **Subd. 2. When abortion not prohibited.** When an abortion upon a woman whose
 313.16 unborn child has been determined to have a probable postfertilization age of 20 or more
 313.17 weeks is not prohibited by this section, the physician shall terminate the pregnancy in the
 313.18 manner which, in reasonable medical judgment, provides the best opportunity for the unborn
 313.19 child to survive unless, in reasonable medical judgment, termination of the pregnancy in
 313.20 that manner would pose a greater risk either of the death of the pregnant woman or of the
 313.21 substantial and irreversible physical impairment of a major bodily function, not including
 313.22 psychological or emotional conditions, of the woman than would other available methods.
 313.23 No such greater risk shall be deemed to exist if it is based on a claim or diagnosis that the
 313.24 woman will engage in conduct which she intends to result in her death or in substantial and
 313.25 irreversible physical impairment of a major bodily function.

313.26 Sec. 30. **[145.4145] ENFORCEMENT.**

313.27 **Subdivision 1. Criminal penalties.** A person who intentionally or recklessly performs
 313.28 or induces or attempts to perform or induce an abortion in violation of sections 145.4141
 313.29 to 145.4147 shall be guilty of a felony. No penalty may be assessed against the woman upon
 313.30 whom the abortion is performed or induced or attempted to be performed or induced.

313.31 **Subd. 2. Civil remedies.** (a) A woman upon whom an abortion has been performed or
 313.32 induced in violation of sections 145.4141 to 145.4147, or the father of the unborn child who
 313.33 was the subject of such an abortion, may maintain an action against the person who performed
 313.34 or induced the abortion in intentional or reckless violation of sections 145.4141 to 145.4147

314.1 for damages. A woman upon whom an abortion has been attempted in violation of sections
314.2 145.4141 to 145.4147 may maintain an action against the person who attempted to perform
314.3 or induce the abortion in an intentional or reckless violation of sections 145.4141 to 145.4147
314.4 for damages.

314.5 (b) A cause of action for injunctive relief against a person who has intentionally violated
314.6 sections 145.4141 to 145.4147 may be maintained by the woman upon whom an abortion
314.7 was performed or induced or attempted to be performed or induced in violation of sections
314.8 145.4141 to 145.4147; by a person who is the father of the unborn child subject to an
314.9 abortion, parent, sibling, or guardian of, or a current or former licensed health care provider
314.10 of, the woman upon whom an abortion has been performed or induced or attempted to be
314.11 performed or induced in violation of sections 145.4141 to 145.4147; by a county attorney
314.12 with appropriate jurisdiction; or by the attorney general. The injunction shall prevent the
314.13 abortion provider from performing or inducing or attempting to perform or induce further
314.14 abortions in this state in violation of sections 145.4141 to 145.4147.

314.15 (c) If judgment is rendered in favor of the plaintiff in an action described in this section,
314.16 the court shall also render judgment for reasonable attorney fees in favor of the plaintiff
314.17 against the defendant.

314.18 (d) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's
314.19 suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable
314.20 attorney fees in favor of the defendant against the plaintiff.

314.21 (e) No damages or attorney fees may be assessed against the woman upon whom an
314.22 abortion was performed or induced or attempted to be performed or induced except according
314.23 to paragraph (d).

314.24 **Sec. 31. [145.4146] PROTECTION OF PRIVACY IN COURT PROCEEDINGS.**

314.25 In every civil or criminal proceeding or action brought under the Pain-Capable Unborn
314.26 Child Protection Act, the court shall rule on whether the anonymity of a woman upon whom
314.27 an abortion has been performed or induced or attempted to be performed or induced shall
314.28 be preserved from public disclosure if she does not give her consent to such disclosure. The
314.29 court, upon motion or sua sponte, shall make such a ruling and, upon determining that her
314.30 anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and
314.31 shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing
314.32 rooms to the extent necessary to safeguard her identity from public disclosure. Each such
314.33 order shall be accompanied by specific written findings explaining why the anonymity of
314.34 the woman should be preserved from public disclosure, why the order is essential to that

315.1 end, how the order is narrowly tailored to serve that interest, and why no reasonable, less
315.2 restrictive alternative exists. In the absence of written consent of the woman upon whom
315.3 an abortion has been performed or induced or attempted to be performed or induced, anyone,
315.4 other than a public official, who brings an action under section 145.4145, subdivision 2,
315.5 shall do so under a pseudonym. This section may not be construed to conceal the identity
315.6 of the plaintiff or of witnesses from the defendant or from attorneys for the defendant.

315.7 Sec. 32. [145.4147] SEVERABILITY.

315.8 If any one or more provisions, sections, subsections, sentences, clauses, phrases, or
315.9 words of sections 145.4141 to 145.4146, or the application thereof to any person or
315.10 circumstance is found to be unconstitutional, the same is hereby declared to be severable
315.11 and the balance of sections 145.4141 to 145.4146 shall remain effective notwithstanding
315.12 such unconstitutionality. The legislature hereby declares that it would have passed sections
315.13 145.4141 to 145.4146, and each provision, section, subsection, sentence, clause, phrase, or
315.14 word thereof, irrespective of the fact that any one or more provisions, sections, subsections,
315.15 sentences, clauses, phrases, or words of sections 145.4141 to 145.4146, or the application
315.16 of sections 145.4141 to 145.4146, would be declared unconstitutional.

315.17 Sec. 33. Minnesota Statutes 2018, section 145.4235, subdivision 2, is amended to read:

315.18 Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible
315.19 applicants under paragraph (c) for the reasonable expenses of alternatives to abortion
315.20 programs to support, encourage, and assist women in carrying their pregnancies to term and
315.21 caring for their babies after birth by providing information on, referral to, and assistance
315.22 with securing necessary services that enable women to carry their pregnancies to term and
315.23 care for their babies after birth. Necessary services must include, but are not limited to:

315.24 (1) medical care;

315.25 (2) nutritional services;

315.26 (3) housing assistance;

315.27 (4) adoption services;

315.28 (5) education and employment assistance, including services that support the continuation
315.29 and completion of high school;

315.30 (6) child care assistance; and

315.31 (7) parenting education and support services.

316.1 An applicant may not provide or assist a woman to obtain adoption services from a provider
316.2 of adoption services that is not licensed.

316.3 (b) In addition to providing information and referral under paragraph (a), an eligible
316.4 program may provide one or more of the necessary services under paragraph (a) that assists
316.5 women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may
316.6 refer to other public or private programs, rather than provide the care directly, if a woman
316.7 meets eligibility criteria for the other programs.

316.8 (c) To be eligible for a grant, an agency or organization must:

316.9 (1) be a private, nonprofit organization;

316.10 (2) demonstrate that the program is conducted under appropriate supervision;

316.11 (3) not charge women for services provided under the program;

316.12 (4) provide each pregnant woman counseled with accurate information on the
316.13 developmental characteristics of babies and of unborn children, including offering the printed
316.14 information described in section 145.4243;

316.15 (5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage
316.16 women in carrying their pregnancies to term and to maximize their potentials thereafter;

316.17 (6) ensure that none of the money provided is used to encourage or affirmatively counsel
316.18 a woman to have an abortion not necessary to prevent her death, to provide her an abortion,
316.19 or to directly refer her to an abortion provider for an abortion. The agency or organization
316.20 may provide nondirective counseling; and

316.21 (7) have had the alternatives to abortion program in existence ~~for at least one year as of~~
316.22 ~~July 1, 2011; or incorporated an alternative to abortion program that has been in existenece~~
316.23 ~~for at least one year as of July 1, 2011~~ for at least two years prior to the date the agency or
316.24 organization submits an application to the commissioner for a grant under this section.

316.25 (d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from
316.26 this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its
316.27 application to any person or circumstance is held invalid, the invalidity applies to all of this
316.28 subdivision.

316.29 (e) An organization that provides abortions, promotes abortions, or directly refers to an
316.30 abortion provider for an abortion is ineligible to receive a grant under this program. An
316.31 affiliate of an organization that provides abortions, promotes abortions, or directly refers
316.32 to an abortion provider for an abortion is ineligible to receive a grant under this section

317.1 unless the organizations are separately incorporated and independent from each other. To
317.2 be independent, the organizations may not share any of the following:

317.3 (1) the same or a similar name;

317.4 (2) medical facilities or nonmedical facilities, including but not limited to, business
317.5 offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

317.6 (3) expenses;

317.7 (4) employee wages or salaries; or

317.8 (5) equipment or supplies, including but not limited to, computers, telephone systems,
317.9 telecommunications equipment, and office supplies.

317.10 (f) An organization that receives a grant under this section and that is affiliated with an
317.11 organization that provides abortion services must maintain financial records that demonstrate
317.12 strict compliance with this subdivision and that demonstrate that its independent affiliate
317.13 that provides abortion services receives no direct or indirect economic or marketing benefit
317.14 from the grant under this section.

317.15 (g) The commissioner shall approve any information provided by a grantee on the health
317.16 risks associated with abortions to ensure that the information is medically accurate.

317.17 Sec. 34. Minnesota Statutes 2018, section 145.4242, is amended to read:

317.18 **145.4242 INFORMED CONSENT.**

317.19 (a) No abortion shall be performed in this state except with the voluntary and informed
317.20 consent of the female upon whom the abortion is to be performed. Except in the case of a
317.21 medical emergency or if the fetus has an anomaly incompatible with life, and the female
317.22 has declined perinatal hospice care, consent to an abortion is voluntary and informed only
317.23 if:

317.24 (1) the female is told the following, by telephone or in person, by the physician who is
317.25 to perform the abortion or by a referring physician, at least 24 hours before the abortion:

317.26 (i) the particular medical risks associated with the particular abortion procedure to be
317.27 employed including, when medically accurate, the risks of infection, hemorrhage, breast
317.28 cancer, danger to subsequent pregnancies, and infertility;

317.29 (ii) the probable gestational age of the unborn child at the time the abortion is to be
317.30 performed;

317.31 (iii) the medical risks associated with carrying her child to term; and

318.1 (iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic
318.2 would eliminate or alleviate organic pain to the unborn child caused by the particular method
318.3 of abortion to be employed and the particular medical benefits and risks associated with the
318.4 particular anesthetic or analgesic.

318.5 The information required by this clause may be provided by telephone without conducting
318.6 a physical examination or tests of the patient, in which case the information required to be
318.7 provided may be based on facts supplied to the physician by the female and whatever other
318.8 relevant information is reasonably available to the physician. It may not be provided by a
318.9 tape recording, but must be provided during a consultation in which the physician is able
318.10 to ask questions of the female and the female is able to ask questions of the physician. If a
318.11 physical examination, tests, or the availability of other information to the physician
318.12 subsequently indicate, in the medical judgment of the physician, a revision of the information
318.13 previously supplied to the patient, that revised information may be communicated to the
318.14 patient at any time prior to the performance of the abortion. Nothing in this section may be
318.15 construed to preclude provision of required information in a language understood by the
318.16 patient through a translator;

318.17 (2) the female is informed, by telephone or in person, by the physician who is to perform
318.18 the abortion, by a referring physician, or by an agent of either physician at least 24 hours
318.19 before the abortion:

318.20 (i) that medical assistance benefits may be available for prenatal care, childbirth, and
318.21 neonatal care;

318.22 (ii) that the father is liable to assist in the support of her child, even in instances when
318.23 the father has offered to pay for the abortion; and

318.24 (iii) that she has the right to review the printed materials described in section 145.4243,
318.25 that these materials are available on a state-sponsored website, and what the website address
318.26 is. The physician or the physician's agent shall orally inform the female that the materials
318.27 have been provided by the state of Minnesota and that they describe the unborn child, list
318.28 agencies that offer alternatives to abortion, and contain information on fetal pain. If the
318.29 female chooses to view the materials other than on the website, they shall either be given
318.30 to her at least 24 hours before the abortion or mailed to her at least 72 hours before the
318.31 abortion by certified mail, restricted delivery to addressee, which means the postal employee
318.32 can only deliver the mail to the addressee.

319.1 The information required by this clause may be provided by a tape recording if provision
319.2 is made to record or otherwise register specifically whether the female does or does not
319.3 choose to have the printed materials given or mailed to her;

319.4 (3) the female certifies in writing, prior to the abortion, that the information described
319.5 in clauses (1) and (2) has been furnished to her and that she has been informed of her
319.6 opportunity to review the information referred to in clause (2), item (iii); and

319.7 (4) prior to the performance of the abortion, the physician who is to perform the abortion
319.8 or the physician's agent obtains a copy of the written certification prescribed by clause (3)
319.9 and retains it on file with the female's medical record for at least three years following the
319.10 date of receipt.

319.11 (b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause
319.12 (1), item (iv), the physician must disclose to the woman any additional cost of the procedure
319.13 for the administration of the anesthetic or analgesic. If the woman consents to the
319.14 administration of the anesthetic or analgesic, the physician shall administer the anesthetic
319.15 or analgesic or arrange to have the anesthetic or analgesic administered.

319.16 (c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly
319.17 incompatible with life must be informed of available perinatal hospice services and offered
319.18 this care as an alternative to abortion. If perinatal hospice services are declined, voluntary
319.19 and informed consent by the female seeking an abortion is given if the female receives the
319.20 information required in paragraphs (a), clause (1), and (b). The female must comply with
319.21 the requirements in paragraph (a), clauses (3) and (4).

319.22 (d) If, at any time prior to the performance of an abortion, a female undergoes an
319.23 ultrasound examination, or a physician determines that ultrasound imaging will be used
319.24 during the course of a patient's abortion, the physician or the physician's agent shall orally
319.25 inform the patient of the opportunity to view or decline to view an active ultrasound image
319.26 of the unborn child.

319.27 Sec. 35. Minnesota Statutes 2018, section 145.4244, is amended to read:

319.28 **145.4244 INTERNET WEBSITE.**

319.29 (a) The commissioner of health shall develop and maintain a stable Internet website to
319.30 provide the information described under section 145.4243. No information regarding who
319.31 uses the website shall be collected or maintained. The commissioner of health shall monitor
319.32 the website on a weekly basis to prevent and correct tampering.

320.1 (b) A health care facility performing abortions must provide the information described
 320.2 in section 145.4243 on the facility's website or provide a link to the Department of Health
 320.3 website where this information may be viewed.

320.4 Sec. 36. Minnesota Statutes 2018, section 145.908, subdivision 1, is amended to read:

320.5 Subdivision 1. **Grant program established.** Within the limits of ~~federal funds~~ available
 320.6 ~~specifically appropriations~~ for this purpose, the commissioner of health shall establish a
 320.7 grant program to provide culturally competent programs to screen and treat pregnant women
 320.8 and women who have given birth in the preceding 12 months for pre- and postpartum mood
 320.9 and anxiety disorders. Organizations may use grant funds to establish new screening or
 320.10 treatment programs, or expand or maintain existing screening or treatment programs. In
 320.11 establishing the grant program, the commissioner shall prioritize expanding or enhancing
 320.12 screening for pre- and postpartum mood and anxiety disorders in primary care settings. The
 320.13 commissioner shall determine the types of organizations eligible for grants.

320.14 Sec. 37. Minnesota Statutes 2018, section 145.928, subdivision 1, is amended to read:

320.15 Subdivision 1. **Goal; establishment.** It is the goal of the state, ~~by 2010,~~ to decrease ~~by~~
 320.16 ~~50 percent~~ the disparities in infant mortality rates and adult and child immunization rates
 320.17 for American Indians and populations of color, as compared with rates for whites. To do
 320.18 so and to achieve other measurable outcomes, the commissioner of health shall establish a
 320.19 program to close the gap in the health status of American Indians and populations of color
 320.20 as compared with whites in the following priority areas: infant mortality, access to and
 320.21 utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS
 320.22 and sexually transmitted infections, adult and child immunizations, cardiovascular disease,
 320.23 diabetes, and accidental injuries and violence.

320.24 Sec. 38. Minnesota Statutes 2018, section 145.928, subdivision 7, is amended to read:

320.25 Subd. 7. **Community grant program; immunization rates, prenatal care access and**
 320.26 **utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible
 320.27 applicants for local or regional projects and initiatives directed at reducing health disparities
 320.28 in one or ~~both~~ more of the following priority areas:

320.29 (1) decreasing racial and ethnic disparities in infant mortality rates; ~~or~~

320.30 (2) decreasing racial and ethnic disparities in access to and utilization of high-quality
 320.31 prenatal care; or

321.1 ~~(2)~~ (3) increasing adult and child immunization rates in nonwhite racial and ethnic
321.2 populations.

321.3 (b) The commissioner may award up to 20 percent of the funds available as planning
321.4 grants. Planning grants must be used to address such areas as community assessment,
321.5 coordination activities, and development of community supported strategies.

321.6 (c) Eligible applicants may include, but are not limited to, faith-based organizations,
321.7 social service organizations, community nonprofit organizations, community health boards,
321.8 tribal governments, and community clinics. Applicants must submit proposals to the
321.9 commissioner. A proposal must specify the strategies to be implemented to address one or
321.10 ~~both~~ more of the priority areas listed in paragraph (a) and must be targeted to achieve the
321.11 outcomes established according to subdivision 3.

321.12 (d) The commissioner shall give priority to applicants who demonstrate that their
321.13 proposed project or initiative:

321.14 (1) is supported by the community the applicant will serve;

321.15 (2) is research-based or based on promising strategies;

321.16 (3) is designed to complement other related community activities;

321.17 (4) utilizes strategies that positively impact ~~both~~ two or more priority areas;

321.18 (5) reflects racially and ethnically appropriate approaches; and

321.19 (6) will be implemented through or with community-based organizations that reflect the
321.20 race or ethnicity of the population to be reached.

321.21 Sec. 39. Minnesota Statutes 2018, section 145.986, subdivision 1, is amended to read:

321.22 Subdivision 1. **Purpose.** The purpose of the statewide health improvement program is
321.23 to:

321.24 (1) address the ~~top three~~ leading preventable causes of illness and death: ~~tobacco use~~
321.25 ~~and exposure, poor diet, and lack of regular physical activity~~ as determined by the
321.26 commissioner through the statewide health assessment;

321.27 (2) promote the development, availability, and use of evidence-based, community level,
321.28 comprehensive strategies to create healthy communities; and

321.29 (3) measure the impact of the evidence-based, community health improvement practices
321.30 which over time work to contain health care costs and reduce chronic diseases.

322.1 Sec. 40. Minnesota Statutes 2018, section 145.986, subdivision 1a, is amended to read:

322.2 Subd. 1a. **Grants to local communities.** (a) ~~Beginning July 1, 2009,~~ The commissioner
322.3 of health shall award competitive grants to community health boards and tribal governments
322.4 to convene, coordinate, and implement ~~evidence-based~~ proven-effective strategies ~~targeted~~
322.5 ~~at reducing the percentage of Minnesotans who are obese or overweight and to reduce the~~
322.6 ~~use of tobacco,~~ and promising practices or activities that can be evaluated using experimental
322.7 or quasi-experimental design. Grants shall be awarded to all community health boards and
322.8 tribal governments whose proposals demonstrate the ability to implement programs designed
322.9 to achieve the purposes in subdivision 1 and other requirements of this section.

322.10 (b) Grantee activities shall:

322.11 (1) be based on scientific evidence;

322.12 (2) be based on community input;

322.13 (3) address behavior change at the individual, community, and systems levels;

322.14 (4) occur in community, school, work site, and health care settings;

322.15 (5) be focused on policy, systems, and environmental changes that support healthy
322.16 behaviors; and

322.17 (6) address the health disparities and inequities that exist in the grantee's community.

322.18 (c) To receive a grant under this section, community health boards and tribal governments
322.19 must submit proposals to the commissioner. A local match of ten percent of the total funding
322.20 allocation is required. This local match may include funds donated by community partners.

322.21 (d) In order to receive a grant, community health boards and tribal governments must
322.22 submit a health improvement plan to the commissioner of health for approval. The
322.23 commissioner may require the plan to identify a community leadership team, community
322.24 partners, and a community action plan that includes an assessment of area strengths and
322.25 needs, proposed action strategies, technical assistance needs, and a staffing plan.

322.26 (e) The grant recipient must implement the health improvement plan, evaluate the
322.27 effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

322.28 (f) Grant recipients shall report their activities and their progress toward the outcomes
322.29 established under subdivision 2 to the commissioner in a format and at a time specified by
322.30 the commissioner.

322.31 (g) All grant recipients shall be held accountable for making progress toward the
322.32 measurable outcomes established in subdivision 2. The commissioner shall require a

323.1 corrective action plan and may reduce the funding level of grant recipients that do not make
323.2 adequate progress toward the measurable outcomes.

323.3 ~~(h) Beginning November 1, 2015, the commissioner shall offer grant recipients the~~
323.4 ~~option of using a grant awarded under this subdivision to implement health improvement~~
323.5 ~~strategies that improve the health status, delay the expression of dementia, or slow the~~
323.6 ~~progression of dementia, for a targeted population at risk for dementia and shall award at~~
323.7 ~~least two of the grants awarded on November 1, 2015, for these purposes. The grants must~~
323.8 ~~meet all other requirements of this section. The commissioner shall coordinate grant planning~~
323.9 ~~activities with the commissioner of human services, the Minnesota Board on Aging, and~~
323.10 ~~community-based organizations with a focus on dementia. Each grant must include selected~~
323.11 ~~outcomes and evaluation measures related to the incidence or progression of dementia~~
323.12 ~~among the targeted population using the procedure described in subdivision 2. For purposes~~
323.13 ~~of this subdivision, "proven-effective strategy" means a strategy or practice that offers a~~
323.14 ~~high level of research on effectiveness for at least one outcome of interest; and "promising~~
323.15 ~~practice or activity" means a practice or activity that is supported by research demonstrating~~
323.16 ~~effectiveness for at least one outcome of interest.~~

323.17 ~~(i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of~~
323.18 ~~using a grant awarded under this subdivision to confront the opioid addiction and overdose~~
323.19 ~~epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for~~
323.20 ~~these purposes. The grants awarded under this paragraph must meet all other requirements~~
323.21 ~~of this section. The commissioner shall coordinate grant planning activities with the~~
323.22 ~~commissioner of human services. Each grant shall include selected outcomes and evaluation~~
323.23 ~~measures related to addressing the opioid epidemic.~~

323.24 Sec. 41. Minnesota Statutes 2018, section 145.986, subdivision 4, is amended to read:

323.25 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the
323.26 commissioner shall conduct a biennial evaluation of the statewide health improvement
323.27 program grants funded under this section. The evaluation must use the most appropriate
323.28 experimental or quasi-experimental design suitable for the grant activity or project. Grant
323.29 recipients shall cooperate with the commissioner in the evaluation and provide the
323.30 commissioner with the information necessary to conduct the evaluation, including information
323.31 on any impact on the health indicators listed in section 62U.10, subdivision 6, within the
323.32 geographic area or among the population targeted.

324.1 (b) Grant recipients will collect, monitor, and submit to the Department of Health baseline
324.2 and annual data and provide information to improve the quality and impact of community
324.3 health improvement strategies.

324.4 (c) For the purposes of carrying out the grant program under this section, including for
324.5 administrative purposes, the commissioner shall award contracts to appropriate entities to
324.6 assist in designing and implementing evaluation systems. The commissioner shall consult
324.7 with the commissioner of management and budget to ensure that the evaluation process is
324.8 using experimental or quasi-experimental design.

324.9 (d) Contracts awarded under paragraph (c) may be used to:

324.10 (1) develop grantee monitoring and reporting systems to track grantee progress, including
324.11 aggregated and disaggregated data;

324.12 (2) manage, analyze, and report program evaluation data results; and

324.13 (3) utilize innovative support tools to analyze and predict the impact of prevention
324.14 strategies on health outcomes and state health care costs over time.

324.15 (e) For purposes of this subdivision, "experimental design" means a method of evaluating
324.16 the impact of a strategy that uses random assignment to establish statistically similar groups,
324.17 so that any difference in outcomes found at the end of the evaluation can be attributed to
324.18 the strategy being evaluated; and "quasi-experimental design" means a method of evaluating
324.19 the impact of a strategy that uses an approach other than random assignment to establish
324.20 statistically similar groups, so that any difference in outcomes found at the end of the
324.21 evaluation can be attributed to the strategy being evaluated.

324.22 Sec. 42. Minnesota Statutes 2018, section 145.986, subdivision 5, is amended to read:

324.23 Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on
324.24 the statewide health improvement program funded under this section. The report must
324.25 include information on each grant recipient, including the activities that were conducted by
324.26 the grantee using grant funds, the grantee's progress toward achieving the measurable
324.27 outcomes established under subdivision 2, and the data provided to the commissioner by
324.28 the grantee to measure these outcomes for grant activities. The commissioner shall provide
324.29 information on grants in which a corrective action plan was required under subdivision 1a,
324.30 the types of plan action, and the progress that has been made toward meeting the measurable
324.31 outcomes. In addition, the commissioner shall provide recommendations on future areas of
324.32 focus for health improvement. These reports are due by January 15 of every other year,
324.33 beginning in 2010. ~~In the report due on January 15, 2014,~~ In the reports due beginning

325.1 January 15, 2020, the commissioner shall include a description of the contracts awarded
325.2 under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were
325.3 designed and implemented under these contracts.

325.4 Sec. 43. Minnesota Statutes 2018, section 145.986, subdivision 6, is amended to read:

325.5 Subd. 6. **Supplantation of existing funds.** Community health boards and tribal
325.6 governments must use funds received under this section to develop new programs, expand
325.7 current programs ~~that work to reduce the percentage of Minnesotans who are obese or~~
325.8 ~~overweight or who use tobacco~~, or replace discontinued state or federal funds ~~previously~~
325.9 ~~used to reduce the percentage of Minnesotans who are obese or overweight or who use~~
325.10 ~~tobacco~~. Funds must not be used to supplant current state or local funding to community
325.11 health boards or tribal governments ~~used to reduce the percentage of Minnesotans who are~~
325.12 ~~obese or overweight or to reduce tobacco use.~~

325.13 Sec. 44. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to
325.14 read:

325.15 Subd. 5a. **Hemp.** "Hemp" means industrial hemp as defined in section 18K.02,
325.16 subdivision 3.

325.17 Sec. 45. Minnesota Statutes 2018, section 152.22, subdivision 6, is amended to read:

325.18 Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus
325.19 cannabis plant, or any mixture or preparation of them, including whole plant extracts and
325.20 resins, and is delivered in the form of:

325.21 (1) liquid, including, but not limited to, oil;

325.22 (2) pill;

325.23 (3) vaporized delivery method with use of liquid or oil but which does not require the
325.24 use of dried leaves or plant form; or

325.25 (4) any other method, excluding smoking, approved by the commissioner.

325.26 (b) This definition includes any part of the genus cannabis plant prior to being processed
325.27 into a form allowed under paragraph (a), that is possessed by a person while that person is
325.28 engaged in employment duties necessary to carry out a requirement under sections 152.22
325.29 to 152.37 for a registered manufacturer or a laboratory under contract with a registered
325.30 manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp

326.1 grower licensed under chapter 18K as permitted under section 152.29, subdivision 1,
326.2 paragraph (b).

326.3 Sec. 46. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

326.4 Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force
326.5 on medical cannabis therapeutic research and to the chairs and ranking minority members
326.6 of the legislative committees with jurisdiction over health and human services, public safety,
326.7 judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions
326.8 regarding the use of medical cannabis and hemp; and (2) the market demand and supply in
326.9 this state for hemp products that can be used for medicinal purposes.

326.10 (b) The commissioner may submit medical research based on the data collected under
326.11 sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority
326.12 over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a
326.13 qualifying medical condition.

326.14 Sec. 47. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

326.15 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in
326.16 the registry program, a health care practitioner shall:

326.17 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
326.18 from a qualifying medical condition, and, if so determined, provide the patient with a
326.19 certification of that diagnosis;

326.20 (2) determine whether a patient is developmentally or physically disabled and, as a result
326.21 of that disability, the patient is unable to self-administer medication or acquire medical
326.22 cannabis from a distribution facility, and, if so determined, include that determination on
326.23 the patient's certification of diagnosis;

326.24 (3) advise patients, registered designated caregivers, and parents or legal guardians who
326.25 are acting as caregivers of the existence of any nonprofit patient support groups or
326.26 organizations;

326.27 (4) provide explanatory information from the commissioner to patients with qualifying
326.28 medical conditions, including disclosure to all patients about the experimental nature of
326.29 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
326.30 proposed treatment; the application and other materials from the commissioner; and provide
326.31 patients with the Tennessee warning as required by section 13.04, subdivision 2; and

327.1 (5) agree to continue treatment of the patient's qualifying medical condition and report
327.2 medical findings to the commissioner.

327.3 (b) Upon notification from the commissioner of the patient's enrollment in the registry
327.4 program, the health care practitioner shall:

327.5 (1) participate in the patient registry reporting system under the guidance and supervision
327.6 of the commissioner;

327.7 (2) report health records of the patient throughout the ongoing treatment of the patient
327.8 to the commissioner in a manner determined by the commissioner and in accordance with
327.9 subdivision 2;

327.10 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
327.11 medical condition and, if so, issue the patient a new certification of that diagnosis; and

327.12 (4) otherwise comply with all requirements developed by the commissioner.

327.13 (c) A health care practitioner may conduct a patient assessment to issue a recertification
327.14 as required under paragraph (b), clause (3), via telemedicine as defined under section
327.15 62A.671, subdivision 9.

327.16 ~~(e)~~ (d) Nothing in this section requires a health care practitioner to participate in the
327.17 registry program.

327.18 Sec. 48. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

327.19 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~
327.20 eight distribution facilities, which may include the manufacturer's single location for
327.21 cultivation, harvesting, manufacturing, packaging, and processing but is not required to
327.22 include that location. ~~A manufacturer is required to begin distribution of medical cannabis~~
327.23 ~~from at least one distribution facility by July 1, 2015. All distribution facilities must be~~
327.24 ~~operational and begin distribution of medical cannabis by July 1, 2016. The distribution~~
327.25 ~~facilities shall be located~~ The commissioner shall designate the geographical service areas
327.26 to be served by each manufacturer based on geographical need throughout the state to
327.27 improve patient access. ~~A manufacturer shall disclose the proposed locations for the~~
327.28 ~~distribution facilities to the commissioner during the registration process. A manufacturer~~
327.29 shall not have more than two distribution facilities in each geographical service area assigned
327.30 to the manufacturer by the commissioner. A manufacturer shall operate only one location
327.31 where all cultivation, harvesting, manufacturing, packaging, and processing of medical
327.32 cannabis shall be conducted. ~~Any~~ This location may be one of the manufacturer's distribution
327.33 facility sites. The additional distribution facilities may dispense medical cannabis and

328.1 medical cannabis products but may not contain any medical cannabis in a form other than
 328.2 those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not
 328.3 conduct any cultivation, harvesting, manufacturing, packaging, or processing at ~~an additional~~
 328.4 the other distribution facility ~~site~~ sites. Any distribution facility operated by the manufacturer
 328.5 is subject to all of the requirements applying to the manufacturer under sections 152.22 to
 328.6 152.37, including, but not limited to, security and distribution requirements.

328.7 (b) A manufacturer may obtain hemp from a hemp grower licensed with the commissioner
 328.8 of agriculture under chapter 18K if the hemp was grown in this state. A manufacturer may
 328.9 use hemp for the purpose of making it available in a form allowable under section 152.22,
 328.10 subdivision 6. Any hemp acquired by a manufacturer under this paragraph is subject to the
 328.11 same quality control program, security and testing requirements, and any other requirement
 328.12 for medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

328.13 ~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by
 328.14 the commissioner, subject to any additional requirements set by the commissioner, for
 328.15 purposes of testing medical cannabis manufactured or hemp acquired by the medical cannabis
 328.16 manufacturer as to content, contamination, and consistency to verify the medical cannabis
 328.17 meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall
 328.18 be paid by the manufacturer.

328.19 ~~(c)~~ (d) The operating documents of a manufacturer must include:

328.20 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
 328.21 record keeping; ~~and~~

328.22 (2) procedures for the implementation of appropriate security measures to deter and
 328.23 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
 328.24 cannabis- ; and

328.25 (3) procedures for the delivery and transportation of hemp between hemp growers
 328.26 licensed under chapter 18K and manufacturers.

328.27 ~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements
 328.28 for the delivery and transportation of hemp, protection of each location by a fully operational
 328.29 security alarm system, facility access controls, perimeter intrusion detection systems, and
 328.30 a personnel identification system.

328.31 ~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care
 328.32 practitioner, or have any financial relationship with a health care practitioner.

329.1 ~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the
329.2 property of the manufacturer.

329.3 ~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

329.4 ~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is
329.5 not subject to the Board of Pharmacy licensure or regulatory requirements under chapter
329.6 151.

329.7 ~~(i)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21
329.8 years of age or who has been convicted of a disqualifying felony offense. An employee of
329.9 a medical cannabis manufacturer must submit a completed criminal history records check
329.10 consent form, a full set of classifiable fingerprints, and the required fees for submission to
329.11 the Bureau of Criminal Apprehension before an employee may begin working with the
329.12 manufacturer. The bureau must conduct a Minnesota criminal history records check and
329.13 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
329.14 Investigation to obtain the applicant's national criminal history record information. The
329.15 bureau shall return the results of the Minnesota and federal criminal history records checks
329.16 to the commissioner.

329.17 ~~(j)~~ (k) A manufacturer may not operate in any location, whether for distribution or
329.18 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
329.19 public or private school existing before the date of the manufacturer's registration with the
329.20 commissioner.

329.21 ~~(k)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
329.22 relating to signage, marketing, display, and advertising of medical cannabis.

329.23 (m) Before a manufacturer acquires hemp, the manufacturer must verify that the person
329.24 from whom the manufacturer is acquiring hemp has a valid license issued by the
329.25 commissioner of agriculture under chapter 18K.

329.26 Sec. 49. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

329.27 Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall
329.28 provide a reliable and ongoing supply of all medical cannabis needed for the registry program.

329.29 (b) All cultivation, harvesting, manufacturing, packaging, and processing of medical
329.30 cannabis or manufacturing, packaging, or processing of hemp acquired by the manufacturer
329.31 must take place in an enclosed, locked facility at a physical address provided to the
329.32 commissioner during the registration process.

330.1 (c) A manufacturer must process and prepare any medical cannabis plant material into
330.2 a form allowable under section 152.22, subdivision 6, prior to distribution of any medical
330.3 cannabis.

330.4 Sec. 50. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

330.5 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
330.6 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
330.7 for the distribution of medical cannabis to a patient.

330.8 (b) A manufacturer may dispense medical cannabis products, whether or not the products
330.9 have been manufactured by the manufacturer, but is not required to dispense medical cannabis
330.10 products.

330.11 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

330.12 (1) verify that the manufacturer has received the registry verification from the
330.13 commissioner for that individual patient;

330.14 (2) verify that the person requesting the distribution of medical cannabis is the patient,
330.15 the patient's registered designated caregiver, or the patient's parent or legal guardian listed
330.16 in the registry verification using the procedures described in section 152.11, subdivision
330.17 2d;

330.18 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

330.19 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
330.20 chapter 151 has consulted with the patient to determine the proper dosage for the individual
330.21 patient after reviewing the ranges of chemical compositions of the medical cannabis and
330.22 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
330.23 consultation may be conducted remotely using a videoconference, so long as the employee
330.24 providing the consultation is able to confirm the identity of the patient, the consultation
330.25 occurs while the patient is at a distribution facility, and the consultation adheres to patient
330.26 privacy requirements that apply to health care services delivered through telemedicine;

330.27 (5) properly package medical cannabis in compliance with the United States Poison
330.28 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
330.29 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
330.30 and individually identifying information, including:

330.31 (i) the patient's name and date of birth;

331.1 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
331.2 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

331.3 (iii) the patient's registry identification number;

331.4 (iv) the chemical composition of the medical cannabis; and

331.5 (v) the dosage; and

331.6 (6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day
331.7 supply of the dosage determined for that patient.

331.8 (d) A manufacturer shall require any employee of the manufacturer who is transporting
331.9 medical cannabis or medical cannabis products to a distribution facility to carry identification
331.10 showing that the person is an employee of the manufacturer.

331.11 Sec. 51. Minnesota Statutes 2018, section 152.29, subdivision 3a, is amended to read:

331.12 Subd. 3a. **Transportation of medical cannabis; staffing.** (a) A medical cannabis
331.13 manufacturer may staff a transport motor vehicle with only one employee if the medical
331.14 cannabis manufacturer is transporting medical cannabis to either a certified laboratory for
331.15 the purpose of testing or a facility for the purpose of disposal. If the medical cannabis
331.16 manufacturer is transporting medical cannabis for any other purpose or destination, the
331.17 transport motor vehicle must be staffed with a minimum of two employees as required by
331.18 rules adopted by the commissioner.

331.19 (b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only
331.20 transporting hemp for any purpose may staff the transport motor vehicle with only one
331.21 employee.

331.22 Sec. 52. Minnesota Statutes 2018, section 152.31, is amended to read:

331.23 **152.31 DATA PRACTICES.**

331.24 (a) Government data in patient files maintained by the commissioner and the health care
331.25 practitioner, and data submitted to or by a medical cannabis manufacturer, are private data
331.26 on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in
331.27 section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13
331.28 and complying with a request from the legislative auditor or the state auditor in the
331.29 performance of official duties. The provisions of section 13.05, subdivision 11, apply to a
331.30 registration agreement entered between the commissioner and a medical cannabis
331.31 manufacturer under section 152.25.

332.1 (b) Not public data maintained by the commissioner may not be used for any purpose
 332.2 not provided for in sections 152.22 to 152.37, and may not be combined or linked in any
 332.3 manner with any other list, dataset, or database.

332.4 (c) The commissioner may execute data sharing arrangements with the commissioner
 332.5 of agriculture to verify licensing information, inspection, and compliance related to hemp
 332.6 growers under chapter 18K.

332.7 Sec. 53. Minnesota Statutes 2018, section 157.22, is amended to read:

332.8 **157.22 EXEMPTIONS.**

332.9 This chapter does not apply to:

332.10 (1) interstate carriers under the supervision of the United States Department of Health
 332.11 and Human Services;

332.12 (2) weddings, fellowship meals, or funerals conducted by a faith-based organization
 332.13 using any building constructed and primarily used for religious worship or education;

332.14 (3) any building owned, operated, and used by a college or university in accordance
 332.15 with health regulations promulgated by the college or university under chapter 14;

332.16 (4) any person, firm, or corporation whose principal mode of business is licensed under
 332.17 sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage
 332.18 establishment; provided that the holding of any license pursuant to sections 28A.04 and
 332.19 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of
 332.20 this chapter or the rules of the state commissioner of health relating to food and beverage
 332.21 service establishments;

332.22 (5) family day care homes and group family day care homes governed by sections
 332.23 245A.01 to 245A.16;

332.24 (6) nonprofit senior citizen centers for the sale of home-baked goods;

332.25 (7) fraternal, sportsman, or patriotic organizations that are tax exempt under section
 332.26 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue
 332.27 Code of 1986, or organizations related to, affiliated with, or supported by such fraternal,
 332.28 sportsman, or patriotic organizations for events held in the building or on the grounds of
 332.29 the organization and at which home-prepared food is donated by organization members for
 332.30 sale at the events, provided:

332.31 (i) the event is not a circus, carnival, or fair;

333.1 (ii) the organization controls the admission of persons to the event, the event agenda, or
333.2 both; and

333.3 (iii) the organization's licensed kitchen is not used in any manner for the event;

333.4 (8) food not prepared at an establishment and brought in by individuals attending a
333.5 potluck event for consumption at the potluck event. An organization sponsoring a potluck
333.6 event under this clause may advertise the potluck event to the public through any means.
333.7 Individuals who are not members of an organization sponsoring a potluck event under this
333.8 clause may attend the potluck event and consume the food at the event. Licensed food
333.9 establishments other than schools cannot be sponsors of potluck events. A school may
333.10 sponsor and hold potluck events in areas of the school other than the school's kitchen,
333.11 provided that the school's kitchen is not used in any manner for the potluck event. For
333.12 purposes of this clause, "school" means a public school as defined in section 120A.05,
333.13 subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at
333.14 which a child is provided with instruction in compliance with sections 120A.22 and 120A.24.
333.15 Potluck event food shall not be brought into a licensed food establishment kitchen;

333.16 (9) a home school in which a child is provided instruction at home;

333.17 (10) school concession stands serving commercially prepared, nonpotentially hazardous
333.18 foods, as defined in Minnesota Rules, chapter 4626;

333.19 (11) group residential facilities of ten or fewer beds licensed by the commissioner of
333.20 human services under Minnesota Rules, chapter 2960, provided the facility employs or
333.21 contracts with a certified food manager under Minnesota Rules, part 4626.2015;

333.22 (12) food served at fund-raisers or community events conducted in the building or on
333.23 the grounds of a faith-based organization, provided that a certified food manager, or a
333.24 volunteer trained in a food safety course, trains the food preparation workers in safe food
333.25 handling practices. This exemption does not apply to faith-based organizations at the state
333.26 agricultural society or county fairs or to faith-based organizations that choose to apply for
333.27 a license;

333.28 (13) food service events conducted following a disaster for purposes of feeding disaster
333.29 relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods,
333.30 as defined in Minnesota Rules, chapter 4626; and

333.31 (14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a
333.32 community-based nonprofit organization, provided:

333.33 (i) the municipality where the event is located approves the event;

334.1 (ii) the sponsoring organization must develop food safety rules and ensure that participants
334.2 follow these rules; and

334.3 (iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign
334.4 or placard must be posted that states: "These products are homemade and not subject to
334.5 state inspection."

334.6 Foods exempt under this clause must be labeled to accurately reflect the name and
334.7 address of the person preparing the foods; and

334.8 (15) a special event food stand or a seasonal temporary food stand provided:

334.9 (i) the stand is operated solely by a person or persons under the age of 14;

334.10 (ii) the stand is located on private property with the permission of the property owner;

334.11 (iii) the stand has gross receipts or contributions of \$1,000 or less in a calendar year;

334.12 and

334.13 (iv) the operator of the stand posts a sign or placard at the site that states "The products
334.14 sold at this stand are not subject to state inspection or regulation.", if the stand offers for
334.15 sale potentially hazardous food as defined in Minnesota Rules, part 4626.0020, subdivision
334.16 62.

334.17 Sec. 54. **DIRECTION TO THE COMMISSIONER OF HEALTH.**

334.18 The commissioner of health shall prescribe the notification and consent form described
334.19 in Minnesota Statutes, section 144.6502, subdivision 6, no later than January 1, 2020. The
334.20 commissioner shall make the form available on the department's website.

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

334.22 Sec. 55. **PERINATAL HOSPICE GRANTS.**

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

334.25 (b) "Eligible program entity" means a hospital, hospice, health care facility, or
334.26 community-based organization. An eligible program entity must have a perinatal hospice
334.27 program coordinator who is eligible to be certified in perinatal loss care.

334.28 (c) "Eligible training entity" means an eligible program entity that has experience
334.29 providing perinatal hospice services, or a qualified individual who is eligible to be certified
334.30 in perinatal loss care and has experience providing perinatal hospice services.

335.1 (d) "Eligible to be certified in perinatal loss care" means an individual who meets the
 335.2 criteria to sit for the perinatal loss care exam, or is already certified in perinatal loss care,
 335.3 by the Hospice and Palliative Credentialing Center.

335.4 (e) "Life-limiting prenatal diagnosis" means a fetal condition diagnosed before birth that
 335.5 will with reasonable certainty result in the death of the child within six months after birth.

335.6 (f) "Perinatal hospice" means comprehensive support to the pregnant woman and her
 335.7 family that includes family-centered multidisciplinary care to meet their medical, spiritual,
 335.8 and emotional needs from the time of a life-limiting prenatal diagnosis through the birth,
 335.9 life, and natural death of the child, and through the postpartum period. Supportive care may
 335.10 be provided by medical staff, counselors, clergy, mental health providers, social workers,
 335.11 geneticists, certified nurse midwives, hospice professionals, and others.

335.12 Subd. 2. **Perinatal hospice development grants.** Perinatal hospice development grants
 335.13 are available to eligible program entities and must be used for expenditures to:

335.14 (1) establish a new perinatal hospice program;

335.15 (2) expand an existing perinatal hospice program;

335.16 (3) recruit a perinatal hospice program coordinator; or

335.17 (4) fund perinatal hospice administrative and coordinator expenses for a period of not
 335.18 more than six months.

335.19 Subd. 3. **Perinatal hospice training grants.** Perinatal hospice training grants are available
 335.20 to eligible training entities and may be used for expenses to enable existing perinatal hospice
 335.21 programs to provide training for members of a multidisciplinary team providing perinatal
 335.22 hospice services. Funds must be used for:

335.23 (1) development and operation of a perinatal hospice training program. The curriculum
 335.24 must include but is not limited to training to provide the following services to families
 335.25 eligible for perinatal hospice:

335.26 (i) counseling at the time of a life-limiting prenatal diagnosis;

335.27 (ii) specialized birth planning;

335.28 (iii) specialized advance care planning;

335.29 (iv) services to address the emotional needs of the family through prenatal and postpartum
 335.30 counseling that:

335.31 (A) helps the family prepare for the death of their child;

336.1 (B) helps the family work within the health care delivery system to create a safe and
 336.2 professionally supported environment where parents can parent their child during their brief
 336.3 life in a way that is meaningful for that family and baby; and

336.4 (C) helps the family with the grief that begins at diagnosis and continues after the death
 336.5 of the child; and

336.6 (v) evidence-based perinatal bereavement care;

336.7 (2) trainer support, including travel expenses and reasonable living expenses during the
 336.8 period of training;

336.9 (3) trainee support, including tuition, books, travel expenses, program fees, and reasonable
 336.10 living expenses during the period of training; or

336.11 (4) materials used in the provision of training.

336.12 Subd. 4. **Perinatal hospice awareness grants.** Perinatal hospice awareness grants are
 336.13 available to eligible program entities and may be used for the creation and distribution of
 336.14 materials promoting awareness of perinatal hospice programs.

336.15 Subd. 5. **Report.** The commissioner of health shall report to the chairs and ranking
 336.16 minority members of the legislative committees with jurisdiction over health and human
 336.17 services finance by February 1, 2023, on how the grant funds have been used.

336.18 Sec. 56. **PLAN FOR A WORKING GROUP ON LINKS BETWEEN HEALTH**
 336.19 **DISPARITIES AND EDUCATIONAL ACHIEVEMENT FOR CHILDREN FROM**
 336.20 **AMERICAN INDIAN COMMUNITIES AND COMMUNITIES OF COLOR.**

336.21 (a) The commissioner of health, in consultation with the commissioner of education,
 336.22 shall develop a plan to convene one or more working groups to:

336.23 (1) examine the links between health disparities and disparities in educational achievement
 336.24 for children from American Indian communities and communities of color; and

336.25 (2) develop recommendations for programs, services, or funding to address health
 336.26 disparities and decrease disparities in educational achievement for children from American
 336.27 Indian communities and communities of color.

336.28 (b) The plan shall include the possible membership of the proposed working group and
 336.29 the duties for the proposed working group.

337.1 (c) The commissioner shall submit the plan for the working group, including proposed
337.2 legislation establishing the working group, to the chairs and ranking minority members of
337.3 the legislative committees with jurisdiction over health and education by February 15, 2020.

337.4 **Sec. 57. SALE OF CERTAIN CANNABINOID PRODUCTS WORKGROUP.**

337.5 (a) The commissioner of health, in consultation with the commissioners of commerce,
337.6 agriculture, and public safety, and the executive director of the Board of Pharmacy, shall
337.7 convene a workgroup to advise the legislature on how to regulate products that contain
337.8 cannabinoids extracted from hemp. For purposes of this section, "hemp" has the meaning
337.9 given to "industrial hemp" in Minnesota Statutes, section 18K.02, subdivision 3.

337.10 (b) The commissioner shall assess the public health and consumer safety impact on the
337.11 sale of cannabinoids derived from hemp and shall develop a regulatory framework of what
337.12 the legislature would need to consider including, but not limited to:

337.13 (1) cultivation standards for industrial hemp if the hemp is used for any product intended
337.14 for human or animal consumption;

337.15 (2) labeling requirements for products containing cannabidoil extracted from hemp,
337.16 including the amount and percentage of cannabidiol in the product, the name of the
337.17 manufacturer of the product, and the ingredients contained in the product;

337.18 (3) possible restrictions of advertising and marketing of the cannabidiol product;

337.19 (4) restrictions of false, misleading, or unsubstantiated health claims;

337.20 (5) requirements for the independent testing of cannabidiol products, including quality
337.21 control and chemical identification;

337.22 (6) safety standards for edible products containing cannabinoids extracted from hemp,
337.23 including container and packaging requirements; and

337.24 (7) any other requirement or procedure the commissioner deems necessary.

337.25 (c) By January 15, 2020, the commissioner of health shall submit the results of the
337.26 workgroup to the chairs and ranking minority members of the legislative committees with
337.27 jurisdiction over public health, consumer protection, public safety, and agriculture.

337.28 **Sec. 58. SHORT TITLE.**

337.29 Minnesota Statutes, sections 145.4141 to 145.4147 may be cited as the "Pain-Capable
337.30 Unborn Child Protection Act."

338.1 Sec. 59. **STUDY ON BREASTFEEDING DISPARITIES; STAKEHOLDER**
338.2 **ENGAGEMENT.**

338.3 (a) The commissioner of health shall work with community stakeholders in Minnesota
338.4 including but not limited to representatives from the Minnesota Breastfeeding Coalition;
338.5 Academy of Lactation Policy and Practice; International Board of Lactation Consultant
338.6 Examiners; DONA International; HealthConnect; Reaching Sisters Everywhere; the La
338.7 Leche League; the women, infants, and children program; hospitals and clinics; local public
338.8 health professionals and organizations; community-based organizations; and representatives
338.9 of populations with low breastfeeding rates to carry out a study to identify barriers,
338.10 challenges, and successes affecting the initiation, duration, and exclusivity of breastfeeding.

338.11 (b) The study must address policy, systemic, and environmental factors that both support
338.12 and create barriers to breastfeeding. The study must also identify and make recommendations
338.13 regarding culturally appropriate practices that have been shown to increase breastfeeding
338.14 rates in populations that have the greatest breastfeeding disparity rates.

338.15 (c) The commissioner shall submit a report on the study with any recommendations to
338.16 the chairs and ranking minority members of the legislative committees with jurisdiction
338.17 over health care policy and finance on or before September 15, 2020.

338.18 Sec. 60. **TRANSITION TO AUTHORIZED ELECTRONIC MONITORING IN**
338.19 **CERTAIN HEALTH CARE FACILITIES.**

338.20 Any resident, resident representative, or other person conducting electronic monitoring
338.21 in a resident's room or private living unit prior to January 1, 2020, must comply with the
338.22 requirements of Minnesota Statutes, section 144.6502, by January 1, 2020.

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

338.24 Sec. 61. **REPEALER.**

338.25 Minnesota Statutes 2018, sections 144.1464; and 144.1911, are repealed.

338.26 **ARTICLE 10**

338.27 **MNSURE**

338.28 Section 1. Minnesota Statutes 2018, section 62V.05, subdivision 2, is amended to read:

338.29 Subd. 2. **Operations funding.** ~~(a) Prior to January 1, 2015, MNsure shall retain or collect~~
338.30 ~~up to 1.5 percent of total premiums for individual and small group market health plans and~~
338.31 ~~dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount~~

339.1 ~~collected shall not exceed a dollar amount equal to 25 percent of the funds collected under~~
 339.2 ~~section 62E.11, subdivision 6, for calendar year 2012.~~

339.3 ~~(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total~~
 339.4 ~~premiums for individual and small group market health plans and dental plans sold through~~
 339.5 ~~MNsure to fund the operations of MNsure, but the amount collected shall not exceed a~~
 339.6 ~~dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision~~
 339.7 ~~6, for calendar year 2012.~~

339.8 ~~(e) (a) Beginning January 1, 2016, through December 31, 2019, MNsure shall retain or~~
 339.9 ~~collect up to 3.5 percent of total premiums for individual and small group market health~~
 339.10 ~~plans and dental plans sold through MNsure to fund the operations of MNsure, but the~~
 339.11 ~~amount collected may never exceed a dollar amount greater than 100 percent of the funds~~
 339.12 ~~collected under section 62E.11, subdivision 6, for calendar year 2012.~~

339.13 ~~(d) For fiscal years 2014 and 2015, the commissioner of management and budget is~~
 339.14 ~~authorized to provide cash flow assistance of up to \$20,000,000 from the special revenue~~
 339.15 ~~fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to~~
 339.16 ~~MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June~~
 339.17 ~~30, 2015.~~

339.18 ~~(b) Beginning January 1, 2020, MNsure shall retain or collect up to two percent of total~~
 339.19 ~~premiums for individual and small group health plans and dental plans sold through MNsure~~
 339.20 ~~to fund the operations of MNsure, but the amount collected may never exceed a dollar~~
 339.21 ~~amount greater than 25 percent of the funds collected under section 62E.11, subdivision 6,~~
 339.22 ~~for calendar year 2012.~~

339.23 ~~(e) (c) Funding for the operations of MNsure shall cover any compensation provided to~~
 339.24 ~~navigators participating in the navigator program.~~

339.25 ~~(d) Interagency agreements between MNsure and the Department of Human Services,~~
 339.26 ~~and the Public Assistance Cost Allocation Plan for the Department of Human Services,~~
 339.27 ~~shall not be modified to reflect any changes to the percentage of premiums that MNsure is~~
 339.28 ~~allowed to retain or collect under this section, and no additional funding shall be transferred~~
 339.29 ~~from the Department of Human Services to MNsure as a result of any changes to the~~
 339.30 ~~percentage of premiums that MNsure is allowed to retain or collect under this section.~~

339.31 Sec. 2. Minnesota Statutes 2018, section 62V.05, subdivision 5, is amended to read:

339.32 Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning
 339.33 January 1, 2015, the board may establish certification requirements for health carriers and

340.1 health plans to be offered through MNsure that satisfy federal requirements under ~~section~~
 340.2 ~~1311(e)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42,
 340.3 section 18031(c)(1).

340.4 (b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory
 340.5 requirements that:

340.6 (1) apply uniformly to all health carriers and health plans in the individual market;

340.7 (2) apply uniformly to all health carriers and health plans in the small group market; and

340.8 (3) satisfy minimum federal certification requirements under ~~section 1311(e)(1) of the~~
 340.9 ~~Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

340.10 (c) In accordance with ~~section 1311(e) of the Affordable Care Act, Public Law 111-148~~
 340.11 United States Code, title 42, section 18031(e), the board shall establish policies and
 340.12 procedures for certification and selection of health plans to be offered as qualified health
 340.13 plans through MNsure. The board shall certify and select a health plan as a qualified health
 340.14 plan to be offered through MNsure, if:

340.15 (1) the health plan meets the minimum certification requirements established in paragraph
 340.16 (a) or the market regulatory requirements in paragraph (b);

340.17 (2) the board determines that making the health plan available through MNsure is in the
 340.18 interest of qualified individuals and qualified employers;

340.19 (3) the health carrier applying to offer the health plan through MNsure also applies to
 340.20 offer health plans at each actuarial value level and service area that the health carrier currently
 340.21 offers in the individual and small group markets; and

340.22 (4) the health carrier does not apply to offer health plans in the individual and small
 340.23 group markets through MNsure under a separate license of a parent organization or holding
 340.24 company under section 60D.15, that is different from what the health carrier offers in the
 340.25 individual and small group markets outside MNsure.

340.26 (d) In determining the interests of qualified individuals and employers under paragraph
 340.27 (c), clause (2), the board may not exclude a health plan for any reason specified under ~~section~~
 340.28 ~~1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148~~ United States Code, title
 340.29 42, section 18031(e)(1)(B). ~~The board may consider:~~

340.30 ~~(1) affordability;~~

340.31 ~~(2) quality and value of health plans;~~

340.32 ~~(3) promotion of prevention and wellness;~~

341.1 ~~(4) promotion of initiatives to reduce health disparities;~~

341.2 ~~(5) market stability and adverse selection;~~

341.3 ~~(6) meaningful choices and access;~~

341.4 ~~(7) alignment and coordination with state agency and private sector purchasing strategies~~

341.5 ~~and payment reform efforts; and~~

341.6 ~~(8) other criteria that the board determines appropriate.~~

341.7 (e) A health plan that meets the minimum certification requirements under paragraph

341.8 (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance

341.9 issued under that section, is deemed to be in the interest of qualified individuals and qualified

341.10 employers. The board shall not establish certification requirements for health carriers and

341.11 health plans for participation in MNsure that are in addition to the certification requirements

341.12 under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations

341.13 and guidance issued under that section. The board shall not determine the cost of, cost-sharing

341.14 elements of, or benefits provided in health plans sold through MNsure.

341.15 ~~(e)~~ (f) For qualified health plans offered through MNsure on or after January 1, 2015,

341.16 the board shall establish policies and procedures under paragraphs (c) and (d) for selection

341.17 of health plans to be offered as qualified health plans through MNsure by February 1 of

341.18 each year, beginning February 1, 2014. The board shall consistently and uniformly apply

341.19 all policies and procedures and any requirements, standards, or criteria to all health carriers

341.20 and health plans. For any policies, procedures, requirements, standards, or criteria that are

341.21 defined as rules under section 14.02, subdivision 4, the board may use the process described

341.22 in subdivision 9.

341.23 ~~(f) For 2014, the board shall not have the power to select health carriers and health plans~~

341.24 ~~for participation in MNsure. The board shall permit all health plans that meet the certification~~

341.25 ~~requirements under section 1311(e)(1) of the Affordable Care Act, Public Law 111-148, to~~

341.26 ~~be offered through MNsure.~~

341.27 (g) Under this subdivision, the board shall have the power to verify that health carriers

341.28 and health plans are properly certified to be eligible for participation in MNsure.

341.29 (h) The board has the authority to decertify health carriers and health plans that fail to

341.30 maintain compliance with ~~section 1311(e)(1) of the Affordable Care Act, Public Law 111-148~~

341.31 United States Code, title 42, section 18031(c)(1).

341.32 (i) For qualified health plans offered through MNsure beginning January 1, 2015, health

341.33 carriers must use the most current addendum for Indian health care providers approved by

342.1 the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with
342.2 Indian health care providers. MNsure shall comply with all future changes in federal law
342.3 with regard to health coverage for the tribes.

342.4 Sec. 3. Minnesota Statutes 2018, section 62V.05, subdivision 10, is amended to read:

342.5 Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter
342.6 into any agreement with health care providers to pay claims.

342.7 (b) Nothing in this subdivision shall prevent MNsure from providing insurance for its
342.8 employees.

342.9 (c) The commissioner of human services shall not bear insurance risk or enter into any
342.10 agreement with providers to pay claims for any health coverage administered by the
342.11 commissioner that is made available for purchase through the MNsure website as a qualifying
342.12 health plan or as an alternative to purchasing a qualifying health plan through MNsure or
342.13 an individual health plan offered outside of MNsure.

342.14 (d) Nothing in this subdivision shall prohibit:

342.15 (1) the commissioner of human services from administering the medical assistance
342.16 program under chapter 256B and the MinnesotaCare program under chapter 256L, as long
342.17 as health coverage under these programs is not purchased by the individual through the
342.18 MNsure Web site; and

342.19 (2) employees of the Department of Human Services from obtaining insurance from the
342.20 state employee group insurance program.

342.21 Sec. 4. Minnesota Statutes 2018, section 62V.08, is amended to read:

342.22 **62V.08 REPORTS.**

342.23 (a) MNsure shall submit a report to the legislature by January 15, 2015, and each January
342.24 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure
342.25 responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures
342.26 that have been implemented to ensure compliance with data practices laws, and a description
342.27 of any violations of data practices laws or procedures; and (5) the effectiveness of the
342.28 outreach and implementation activities of MNsure in reducing the rate of uninsurance.

342.29 (b) MNsure must publish its administrative and operational costs on a website to educate
342.30 consumers on those costs. The information published must include: (1) the amount of
342.31 premiums and federal premium subsidies collected; (2) the amount and source of revenue

343.1 received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and
343.2 source of any other fees collected for purposes of supporting operations; and (4) any misuse
343.3 of funds as identified in accordance with section 3.975. The website must be updated at
343.4 least annually.

343.5 (c) As part of the report required to be submitted to the legislature in paragraph (a), and
343.6 the information required to be published in paragraph (b), MNsure shall include the total
343.7 amount spent on business continuity planning, data privacy protection, and cyber security
343.8 provisions.

343.9 Sec. 5. Laws 2015, chapter 71, article 12, section 8, is amended to read:

343.10 **Sec. 8. EXPANDED ACCESS TO QUALIFIED HEALTH PLANS AND SUBSIDIES.**

343.11 The commissioner of commerce, in consultation with the Board of Directors of MNsure
343.12 and the MNsure Legislative Oversight Committee, shall develop a proposal to allow
343.13 individuals to purchase qualified health plans outside of MNsure directly from health plan
343.14 companies and to allow eligible individuals to receive advanced premium tax credits and
343.15 cost-sharing reductions when purchasing these health plans. The commissioner shall seek
343.16 all federal waivers and approvals necessary to implement this proposal and shall submit the
343.17 necessary federal waivers and approvals to the federal government no later than October 1,
343.18 2019. The commissioner shall submit a draft proposal to the MNsure board and the MNsure
343.19 Legislative Oversight Committee ~~at least 30 days before submitting a final proposal to the~~
343.20 ~~federal government~~ no later than September 1, 2019, and shall notify the board and legislative
343.21 oversight committee of any federal decision or action related to the proposal.

343.22 **Sec. 6. MNSURE PROGRAM DEVELOPMENT.**

343.23 No funds shall be appropriated to the Board of Directors of MNsure for new program
343.24 development until 834 EDI transmissions are being processed automatically and are
343.25 conveying accurate information without the intervention of manual reviews and processes.

343.26 **Sec. 7. RATES FOR INDIVIDUAL MARKET HEALTH AND DENTAL PLANS**
343.27 **FOR 2020.**

343.28 (a) Health carriers must take into account the reduction in the premium withhold
343.29 percentage under Minnesota Statutes, section 62V.05, subdivision 2, applicable beginning
343.30 in calendar year 2020 for individual market health plans and dental plans sold through

344.1 MNsure when setting rates for individual market health plans and dental plans for calendar
 344.2 year 2020.

344.3 (b) For purposes of this section, "dental plan," "health carrier," "health plan," and
 344.4 "individual market" have the meanings given in Minnesota Statutes, section 62V.02.

344.5 **Sec. 8. REQUEST FOR INFORMATION ON A PRIVATIZED STATE-BASED**
 344.6 **MARKETPLACE SYSTEM.**

344.7 (a) The commissioner of human services, in consultation with the commissioners of
 344.8 commerce and health, and interested stakeholders, shall develop a request for information
 344.9 to consider the feasibility for a private vendor to provide the technology functionality for
 344.10 the individual market currently provided by MNsure. The request shall seek options for a
 344.11 privately run automated web-based broker system that provides certain core functions
 344.12 including eligibility and enrollment functions, consumer outreach and assistance, and the
 344.13 ability for consumers to compare and choose different qualified health plans. The system
 344.14 must have the ability to integrate with the federal data hub and have account transfer
 344.15 functionality to accept application handoffs compatible with the Medicaid and MinnesotaCare
 344.16 eligibility and enrollment system maintained by the Department of Human Services.

344.17 (b) The commissioner shall report to the chairs and ranking minority members of the
 344.18 legislative committees with jurisdiction over health insurance by February 15, 2020, the
 344.19 results of the request for information and an analysis of the option for a privatized
 344.20 marketplace, including estimated costs.

344.21 **ARTICLE 11**

344.22 **HEALTH LICENSING BOARDS**

344.23 Section 1. Minnesota Statutes 2018, section 148.59, is amended to read:

344.24 **148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.**

344.25 A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board
 344.26 in order to renew a license as provided by board rule. No fees shall be refunded. Fees may
 344.27 not exceed the following amounts but may be adjusted lower by board direction and are for
 344.28 the exclusive use of the board:

344.29 (1) optometry licensure application, \$160;

344.30 (2) optometry annual licensure renewal, ~~\$135~~ \$170;

344.31 (3) optometry late penalty fee, \$75;

- 345.1 (4) annual license renewal card, \$10;
- 345.2 (5) continuing education provider application, \$45;
- 345.3 (6) emeritus registration, \$10;
- 345.4 (7) endorsement/reciprocity application, \$160;
- 345.5 (8) replacement of initial license, \$12; ~~and~~
- 345.6 (9) license verification, \$50~~;~~;
- 345.7 (10) jurisprudence state examination, \$75;
- 345.8 (11) Optometric Education Continuing Education data bank registration, \$20; and
- 345.9 (12) data requests and labels, \$50.

345.10 Sec. 2. Minnesota Statutes 2018, section 148E.180, is amended to read:

345.11 **148E.180 FEE AMOUNTS.**

345.12 Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as~~
 345.13 ~~follows~~ may not exceed the following amounts:

- 345.14 (1) for a licensed social worker, ~~\$45~~ \$54;
- 345.15 (2) for a licensed graduate social worker, ~~\$45~~ \$54;
- 345.16 (3) for a licensed independent social worker, ~~\$45~~ \$54;
- 345.17 (4) for a licensed independent clinical social worker, ~~\$45~~ \$54;
- 345.18 (5) for a temporary license, \$50; and
- 345.19 (6) for a licensure by endorsement, ~~\$85~~ \$92.

345.20 The fee for criminal background checks is the fee charged by the Bureau of Criminal
 345.21 Apprehension. The criminal background check fee must be included with the application
 345.22 fee as required according to section 148E.055.

345.23 Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the
 345.24 following amounts but may be adjusted lower by board action:

- 345.25 (1) for a licensed social worker, ~~\$81~~ \$97;
- 345.26 (2) for a licensed graduate social worker, ~~\$144~~ \$172;
- 345.27 (3) for a licensed independent social worker, ~~\$216~~ \$258;
- 345.28 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$284;

346.1 (5) for an emeritus inactive license, ~~\$43.20~~ \$51;

346.2 (6) for an emeritus active license, one-half of the renewal fee specified in subdivision
346.3 3; and

346.4 (7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

346.5 If the licensee's initial license term is less or more than 24 months, the required license
346.6 fees must be prorated proportionately.

346.7 Subd. 3. **Renewal fees.** Nonrefundable renewal fees for licensure are as follows the
346.8 two-year renewal term may not exceed the following amounts but may be adjusted lower
346.9 by board action:

346.10 (1) for a licensed social worker, ~~\$81~~ \$97;

346.11 (2) for a licensed graduate social worker, ~~\$144~~ \$172;

346.12 (3) for a licensed independent social worker, ~~\$216~~ \$258; and

346.13 (4) for a licensed independent clinical social worker, ~~\$238.50~~ \$284.

346.14 Subd. 4. **Continuing education provider fees.** Continuing education provider fees are
346.15 as follows the following nonrefundable amounts:

346.16 (1) for a provider who offers programs totaling one to eight clock hours in a one-year
346.17 period according to section 148E.145, ~~\$50~~ \$60;

346.18 (2) for a provider who offers programs totaling nine to 16 clock hours in a one-year
346.19 period according to section 148E.145, ~~\$100~~ \$120;

346.20 (3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period
346.21 according to section 148E.145, ~~\$200~~ \$240;

346.22 (4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period
346.23 according to section 148E.145, ~~\$400~~ \$480; and

346.24 (5) for a provider who offers programs totaling 49 or more clock hours in a one-year
346.25 period according to section 148E.145, ~~\$600~~ \$720.

346.26 Subd. 5. **Late fees.** Late fees are as follows the following nonrefundable amounts:

346.27 (1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

346.28 (2) supervision plan late fee, \$40; and

347.1 (3) license late fee, \$100 plus the prorated share of the license fee specified in subdivision
347.2 2 for the number of months during which the individual practiced social work without a
347.3 license.

347.4 Subd. 6. **License cards and wall certificates.** (a) The fee for a license card as specified
347.5 in section 148E.095 is \$10.

347.6 (b) The fee for a license wall certificate as specified in section 148E.095 is \$30.

347.7 Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable
347.8 amounts:

347.9 (1) reactivation from a temporary leave or emeritus status, the prorated share of the
347.10 renewal fee specified in subdivision 3; and

347.11 (2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision
347.12 3.

347.13 Sec. 3. Minnesota Statutes 2018, section 150A.06, subdivision 3, is amended to read:

347.14 Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists,
347.15 dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of
347.16 Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board,
347.17 be waived for an applicant who presents a certificate of having passed all components of
347.18 the National Board Dental Examinations or evidence of having maintained an adequate
347.19 scholastic standing as determined by the board.

347.20 (b) The board shall waive the clinical examination required for licensure for any dentist
347.21 applicant who is a graduate of a dental school accredited by the Commission on Dental
347.22 Accreditation, who has passed all components of the National Board Dental Examinations,
347.23 and who has satisfactorily completed a ~~Minnesota-based~~ postdoctoral general dentistry
347.24 residency program (GPR) or an advanced education in general dentistry (AEGD) program
347.25 after January 1, 2004. The postdoctoral program must be accredited by the Commission on
347.26 Dental Accreditation, be of at least one year's duration, and include an outcome assessment
347.27 evaluation assessing the resident's competence to practice dentistry. The board may require
347.28 the applicant to submit any information deemed necessary by the board to determine whether
347.29 the waiver is applicable.

348.1 Sec. 4. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to
348.2 read:

348.3 Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental
348.4 therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules,
348.5 part 3100.8500, who retires from active practice in the state may apply to the board for
348.6 emeritus inactive licensure. An application for emeritus inactive licensure may be made on
348.7 the biennial licensing form or by petitioning the board, and the applicant must pay a onetime
348.8 application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus
348.9 inactive licensure, the applicant must be in compliance with board requirements and cannot
348.10 be the subject of current disciplinary action resulting in suspension, revocation,
348.11 disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy,
348.12 dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice,
348.13 but is a formal recognition of completion of a person's dental career in good standing.

348.14 Sec. 5. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to
348.15 read:

348.16 Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental
348.17 therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the
348.18 person is retired from active practice, is in compliance with board requirements, and is not
348.19 the subject of current disciplinary action resulting in suspension, revocation, disqualification,
348.20 condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene,
348.21 or dental assisting.

348.22 (b) An emeritus active licensee may engage only in the following types of practice:

348.23 (1) pro bono or volunteer dental practice;

348.24 (2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of
348.25 providing licensing supervision to meet the board's requirements; or

348.26 (3) paid consulting services not to exceed 500 hours per calendar year.

348.27 (c) An emeritus active licensee shall not hold out as a full licensee and may only hold
348.28 out as authorized to practice as described in this subdivision. The board may take disciplinary
348.29 or corrective action against an emeritus active licensee based on violations of applicable
348.30 law or board requirements.

348.31 (d) A person may apply for an emeritus active license by completing an application form
348.32 specified by the board and must pay the application fee pursuant to section 150A.091,
348.33 subdivision 20.

349.1 (e) If an emeritus active license is not renewed every two years, the license expires. The
 349.2 renewal date is the same as the licensee's renewal date when the licensee was in active
 349.3 practice. In order to renew an emeritus active license, the licensee must:

349.4 (1) complete an application form as specified by the board;

349.5 (2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

349.6 (3) report at least 25 continuing education hours completed since the last renewal, which
 349.7 must include:

349.8 (i) at least one hour in two different required CORE areas;

349.9 (ii) at least one hour of mandatory infection control;

349.10 (iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists
 349.11 and dental therapists, and for dental hygienists and dental assistants, at least seven hours of
 349.12 fundamental credits; and

349.13 (iv) for dentists and dental therapists, no more than ten elective credits, and for dental
 349.14 hygienists and dental assistants, no more than six elective credits.

349.15 Sec. 6. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
 349.16 to read:

349.17 Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive
 349.18 licensure under section 150A.06, subdivision 10, must pay a onetime fee of \$50. There is
 349.19 no renewal fee for an emeritus inactive license.

349.20 Sec. 7. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision
 349.21 to read:

349.22 Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure
 349.23 under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal
 349.24 every two years. The fees for emeritus active license application and renewal are as follows:
 349.25 dentist, \$212; dental therapist, \$100; dental hygienist, \$75; and dental assistant, \$55.

349.26 Sec. 8. Minnesota Statutes 2018, section 151.01, subdivision 23, is amended to read:

349.27 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
 349.28 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
 349.29 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed
 349.30 advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.211,

350.1 subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f);
350.2 and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense,
350.3 and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.211,
350.4 subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461,
350.5 "practitioner" also means a dental therapist authorized to dispense and administer under
350.6 chapter 150A.

350.7 Sec. 9. Minnesota Statutes 2018, section 151.06, is amended by adding a subdivision to
350.8 read:

350.9 Subd. 6. **Information provision; sources of lower cost prescription drugs.** (a) The
350.10 board shall publish a page on its website that provides regularly updated information
350.11 concerning:

350.12 (1) patient assistance programs offered by drug manufacturers, including information
350.13 on how to access the programs;

350.14 (2) the prescription drug assistance program established by the Minnesota Board of
350.15 Aging under section 256.975, subdivision 9;

350.16 (3) the websites through which individuals can access information concerning eligibility
350.17 for and enrollment in Medicare, medical assistance, MinnesotaCare, and other
350.18 government-funded programs that help pay for the cost of health care;

350.19 (4) availability of providers that are authorized to participate under section 340b of the
350.20 federal Public Health Services Act, United States Code, title 42, section 256b;

350.21 (5) having a discussion with the pharmacist or the consumer's health care provider about
350.22 alternatives to a prescribed drug, including a lower cost or generic drug if the drug prescribed
350.23 is too costly for the consumer; and

350.24 (6) any other resource that the board deems useful to individuals who are attempting to
350.25 purchase prescription drugs at lower costs.

350.26 (b) The board must prepare educational materials, including brochures and posters, based
350.27 on the information it provides on its website under paragraph (a). The materials must be in
350.28 a form that can be downloaded from the board's website and used for patient education by
350.29 pharmacists and by health care practitioners who are licensed to prescribe. The board is not
350.30 required to provide printed copies of these materials.

351.1 (c) The board shall require pharmacists and pharmacies to make available to patients
351.2 information on sources of lower cost prescription drugs, including information on the
351.3 availability of the website established under paragraph (a).

351.4 Sec. 10. Minnesota Statutes 2018, section 151.211, subdivision 2, is amended to read:

351.5 Subd. 2. **Refill requirements.** Except as provided in subdivision 3, a prescription drug
351.6 order may be refilled only with the written, electronic, or verbal consent of the prescriber
351.7 and in accordance with the requirements of this chapter, the rules of the board, and where
351.8 applicable, section 152.11. The date of such refill must be recorded and initialed upon the
351.9 original prescription drug order, or within the electronically maintained record of the original
351.10 prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the
351.11 prescription.

351.12 Sec. 11. Minnesota Statutes 2018, section 151.211, is amended by adding a subdivision
351.13 to read:

351.14 Subd. 3. **Emergency prescription refills.** (a) A pharmacist may, using sound professional
351.15 judgment and in accordance with accepted standards of practice, dispense a legend drug
351.16 without a current prescription drug order from a licensed practitioner if all of the following
351.17 conditions are met:

351.18 (1) the patient has been compliant with taking the medication and has consistently had
351.19 the drug filled or refilled as demonstrated by records maintained by the pharmacy;

351.20 (2) the pharmacy from which the legend drug is dispensed has record of a prescription
351.21 drug order for the drug in the name of the patient who is requesting it, but the prescription
351.22 drug order does not provide for a refill, or the time during which the refills were valid has
351.23 elapsed;

351.24 (3) the pharmacist has tried but is unable to contact the practitioner who issued the
351.25 prescription drug order, or another practitioner responsible for the patient's care, to obtain
351.26 authorization to refill the prescription;

351.27 (4) the drug is essential to sustain the life of the patient or to continue therapy for a
351.28 chronic condition;

351.29 (5) failure to dispense the drug to the patient would result in harm to the health of the
351.30 patient; and

352.1 (6) the drug is not a controlled substance listed in section 152.02, subdivisions 3 to 6,
352.2 except for a controlled substance that has been specifically prescribed to treat a seizure
352.3 disorder, in which case the pharmacist may dispense up to a 72-hour supply.

352.4 (b) If the conditions in paragraph (a) are met, the amount of the drug dispensed by the
352.5 pharmacist to the patient must not exceed a 30-day supply, or the quantity originally
352.6 prescribed, whichever is less, except as provided for controlled substances in paragraph (a),
352.7 clause (6). If the standard unit of dispensing for the drug exceeds a 30-day supply, the
352.8 amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

352.9 (c) A pharmacist shall not dispense or sell the same drug to the same patient, as provided
352.10 in this section, more than one time in any 12-month period.

352.11 (d) A pharmacist must notify the practitioner who issued the prescription drug order not
352.12 later than 72 hours after the drug is sold or dispensed. The pharmacist must request and
352.13 receive authorization before any additional refills may be dispensed. If the practitioner
352.14 declines to provide authorization for additional refills, the pharmacist must inform the patient
352.15 of that fact.

352.16 (e) The record of a drug sold or dispensed under this section shall be maintained in the
352.17 same manner required for prescription drug orders under this section.

352.18 Sec. 12. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

352.19 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision,
352.20 the data submitted to the board under subdivision 4 is private data on individuals as defined
352.21 in section 13.02, subdivision 12, and not subject to public disclosure.

352.22 (b) Except as specified in subdivision 5, the following persons shall be considered
352.23 permissible users and may access the data submitted under subdivision 4 in the same or
352.24 similar manner, and for the same or similar purposes, as those persons who are authorized
352.25 to access similar private data on individuals under federal and state law:

352.26 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
352.27 delegated the task of accessing the data, to the extent the information relates specifically to
352.28 a current patient, to whom the prescriber is:

352.29 (i) prescribing or considering prescribing any controlled substance;

352.30 (ii) providing emergency medical treatment for which access to the data may be necessary;

352.31 (iii) providing care, and the prescriber has reason to believe, based on clinically valid
352.32 indications, that the patient is potentially abusing a controlled substance; or

353.1 (iv) providing other medical treatment for which access to the data may be necessary
353.2 for a clinically valid purpose and the patient has consented to access to the submitted data,
353.3 and with the provision that the prescriber remains responsible for the use or misuse of data
353.4 accessed by a delegated agent or employee;

353.5 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
353.6 delegated the task of accessing the data, to the extent the information relates specifically to
353.7 a current patient to whom that dispenser is dispensing or considering dispensing any
353.8 controlled substance and with the provision that the dispenser remains responsible for the
353.9 use or misuse of data accessed by a delegated agent or employee;

353.10 (3) a licensed pharmacist who is providing pharmaceutical care for which access to the
353.11 data may be necessary to the extent that the information relates specifically to a current
353.12 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has
353.13 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber
353.14 who is requesting data in accordance with clause (1);

353.15 (4) an individual who is the recipient of a controlled substance prescription for which
353.16 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian
353.17 of a minor, or health care agent of the individual acting under a health care directive under
353.18 chapter 145C;

353.19 (5) personnel or designees of a health-related licensing board listed in section 214.01,
353.20 subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct
353.21 a bona fide investigation of a complaint received by that board that alleges that a specific
353.22 licensee is impaired by use of a drug for which data is collected under subdivision 4, has
353.23 engaged in activity that would constitute a crime as defined in section 152.025, or has
353.24 engaged in the behavior specified in subdivision 5, paragraph (a);

353.25 (6) personnel of the board engaged in the collection, review, and analysis of controlled
353.26 substance prescription information as part of the assigned duties and responsibilities under
353.27 this section;

353.28 (7) authorized personnel of a vendor under contract with the state of Minnesota who are
353.29 engaged in the design, implementation, operation, and maintenance of the prescription
353.30 monitoring program as part of the assigned duties and responsibilities of their employment,
353.31 provided that access to data is limited to the minimum amount necessary to carry out such
353.32 duties and responsibilities, and subject to the requirement of de-identification and time limit
353.33 on retention of data specified in subdivision 5, paragraphs (d) and (e);

354.1 (8) federal, state, and local law enforcement authorities acting pursuant to a valid search
354.2 warrant;

354.3 (9) personnel of the Minnesota health care programs assigned to use the data collected
354.4 under this section to identify and manage recipients whose usage of controlled substances
354.5 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and
354.6 a single hospital;

354.7 (10) personnel of the Department of Human Services assigned to access the data pursuant
354.8 to paragraph (i);

354.9 (11) personnel of the health professionals services program established under section
354.10 214.31, to the extent that the information relates specifically to an individual who is currently
354.11 enrolled in and being monitored by the program, and the individual consents to access to
354.12 that information. The health professionals services program personnel shall not provide this
354.13 data to a health-related licensing board or the Emergency Medical Services Regulatory
354.14 Board, except as permitted under section 214.33, subdivision 3.

354.15 For purposes of clause (4), access by an individual includes persons in the definition of
354.16 an individual under section 13.02; and

354.17 (12) personnel or designees of a health-related licensing board listed in section 214.01,
354.18 subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that
354.19 board that alleges that a specific licensee is inappropriately prescribing controlled substances
354.20 as defined in this section.

354.21 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed
354.22 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe
354.23 controlled substances for humans and who holds a current registration issued by the federal
354.24 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing
354.25 within the state, shall register and maintain a user account with the prescription monitoring
354.26 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration
354.27 application process, other than their name, license number, and license type, is classified
354.28 as private pursuant to section 13.02, subdivision 12.

354.29 (d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9),
354.30 and (10), may directly access the data electronically. No other permissible users may directly
354.31 access the data electronically. If the data is directly accessed electronically, the permissible
354.32 user shall implement and maintain a comprehensive information security program that
354.33 contains administrative, technical, and physical safeguards that are appropriate to the user's
354.34 size and complexity, and the sensitivity of the personal information obtained. The permissible

355.1 user shall identify reasonably foreseeable internal and external risks to the security,
355.2 confidentiality, and integrity of personal information that could result in the unauthorized
355.3 disclosure, misuse, or other compromise of the information and assess the sufficiency of
355.4 any safeguards in place to control the risks.

355.5 (e) The board shall not release data submitted under subdivision 4 unless it is provided
355.6 with evidence, satisfactory to the board, that the person requesting the information is entitled
355.7 to receive the data.

355.8 (f) The board shall maintain a log of all persons who access the data for a period of at
355.9 least three years and shall ensure that any permissible user complies with paragraph ~~(e)~~ (d)
355.10 prior to attaining direct access to the data.

355.11 (g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant
355.12 to subdivision 2. A vendor shall not use data collected under this section for any purpose
355.13 not specified in this section.

355.14 (h) The board may participate in an interstate prescription monitoring program data
355.15 exchange system provided that permissible users in other states have access to the data only
355.16 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract
355.17 or memorandum of understanding that the board enters into under this paragraph.

355.18 (i) With available appropriations, the commissioner of human services shall establish
355.19 and implement a system through which the Department of Human Services shall routinely
355.20 access the data for the purpose of determining whether any client enrolled in an opioid
355.21 treatment program licensed according to chapter 245A has been prescribed or dispensed a
355.22 controlled substance in addition to that administered or dispensed by the opioid treatment
355.23 program. When the commissioner determines there have been multiple prescribers or multiple
355.24 prescriptions of controlled substances, the commissioner shall:

355.25 (1) inform the medical director of the opioid treatment program only that the
355.26 commissioner determined the existence of multiple prescribers or multiple prescriptions of
355.27 controlled substances; and

355.28 (2) direct the medical director of the opioid treatment program to access the data directly,
355.29 review the effect of the multiple prescribers or multiple prescriptions, and document the
355.30 review.

355.31 If determined necessary, the commissioner of human services shall seek a federal waiver
355.32 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section
355.33 2.34, paragraph (c), prior to implementing this paragraph.

356.1 (j) The board shall review the data submitted under subdivision 4 on at least a quarterly
356.2 basis and shall establish criteria, in consultation with the advisory task force, for referring
356.3 information about a patient to prescribers and dispensers who prescribed or dispensed the
356.4 prescriptions in question if the criteria are met.

356.5 (k) The board shall conduct random audits, on at least a quarterly basis, of electronic
356.6 access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9),
356.7 and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined
356.8 in this section. A permissible user whose account has been selected for a random audit shall
356.9 respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit
356.10 is being conducted. Failure to respond may result in deactivation of access to the electronic
356.11 system and referral to the appropriate health licensing board, or the commissioner of human
356.12 services, for further action.

356.13 (l) A permissible user who has delegated the task of accessing the data in subdivision 4
356.14 to an agent or employee shall audit the use of the electronic system by delegated agents or
356.15 employees on at least a quarterly basis to ensure compliance with permissible use as defined
356.16 in this section. When a delegated agent or employee has been identified as inappropriately
356.17 accessing data, the permissible user must immediately remove access for that individual
356.18 and notify the board within seven days. The board shall notify all permissible users associated
356.19 with the delegated agent or employee of the alleged violation.

356.20 **Sec. 13. [214.122] INFORMATION PROVISION; PHARMACEUTICAL**
356.21 **ASSISTANCE PROGRAMS.**

356.22 (a) The Board of Medical Practice and the Board of Nursing shall at least annually inform
356.23 licensees who are authorized to prescribe prescription drugs of the availability of the Board
356.24 of Pharmacy's website that contains information on resources and programs to assist patients
356.25 with the cost of prescription drugs. The boards shall provide licensees with the website
356.26 address established by the Board of Pharmacy under section 151.06, subdivision 6, and the
356.27 materials described under section 151.06, subdivision 6, paragraph (b).

356.28 (b) Licensees must make available to patients information on sources of lower cost
356.29 prescription drugs, including information on the availability of the website established by
356.30 the Board of Pharmacy under section 151.06, subdivision 6.

357.1 **Sec. 14. GUIDELINES AUTHORIZING PATIENT-ASSISTED MEDICATION**
 357.2 **ADMINISTRATION IN EMERGENCIES.**

357.3 (a) Within the limits of the board's available appropriation, the Emergency Medical
 357.4 Services Regulatory Board shall propose guidelines authorizing EMTs, AEMTs, and
 357.5 paramedics certified under Minnesota Statutes, section 144E.28, to assist a patient in
 357.6 emergency situations with administering prescription medications that are:

357.7 (1) carried by a patient;

357.8 (2) intended to treat adrenal insufficiency or other rare conditions that require emergency
 357.9 treatment with a previously prescribed medication;

357.10 (3) intended to treat a specific life-threatening condition; and

357.11 (4) administered via routes of delivery that are within the scope of training of the EMT,
 357.12 AEMT, or paramedic.

357.13 (b) The Emergency Medical Services Regulatory Board shall submit the proposed
 357.14 guidelines and draft legislation as necessary to the chairs and ranking minority members of
 357.15 the legislative committees with jurisdiction over health care by January 1, 2020.

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

357.17 **ARTICLE 12**

357.18 **MISCELLANEOUS**

357.19 Section 1. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision
 357.20 to read:

357.21 Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive
 357.22 mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for
 357.23 breast cancer, and (2) is covered as a preventive item or service, as described under section
 357.24 62Q.46.

357.25 (b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic
 357.26 procedure that involves the acquisition of projection images over the stationary breast to
 357.27 produce cross-sectional digital three-dimensional images of the breast. "At risk for breast
 357.28 cancer" means:

357.29 (1) having a family history with one or more first- or second-degree relatives with breast
 357.30 cancer;

357.31 (2) testing positive for BRCA1 or BRCA2 mutations;

358.1 (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast
358.2 Imaging Reporting and Data System established by the American College of Radiology; or
358.3 (4) having a previous diagnosis of breast cancer.

358.4 (c) This subdivision does not apply to coverage provided through a public health care
358.5 program under chapter 256B or 256L.

358.6 (d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a
358.7 policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to
358.8 January 1, 2020.

358.9 (e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred
358.10 to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at
358.11 risk for breast cancer.

358.12 **EFFECTIVE DATE.** This section is effective January 1, 2020, and applies to health
358.13 plans issued, sold, or renewed on or after that date.

358.14 Sec. 2. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to
358.15 read:

358.16 Subd. 20. **Dividends, distributions, or transfers.** (a) A for-profit health maintenance
358.17 organization may pay dividends or make distributions or transfers, including to a legal entity
358.18 that is an affiliate of the health maintenance organization or that is a subsidiary corporation
358.19 of a local unit of government organized under chapter 383B, in accordance with section
358.20 60D.20, subdivision 2, except that the commissioner referenced in section 60D.20,
358.21 subdivision 2, shall be the commissioner of health.

358.22 (b) If a nonprofit health maintenance organization plans on distributing or transferring
358.23 an amount, including to a legal entity that is an affiliate of the health maintenance
358.24 organization or that is a subsidiary corporation of a local unit of government organized
358.25 under chapter 383B, that together with other distributions or transfers made within the
358.26 preceding 12 months exceeds the greater of: (1) ten percent of the health maintenance
358.27 organization's net worth on December 31 of the preceding year; or (2) the health maintenance
358.28 organization's net income, not including realized capital gains, for the 12-month period
358.29 ending on December 31 of the preceding year, but does not include pro rata distributions
358.30 of any class of the health maintenance organization's own securities, the health maintenance
358.31 organization must meet the requirements of paragraph (c).

358.32 (c) Prior to making a distribution or transfer identified in paragraph (b), a nonprofit
358.33 health maintenance organization must notify the commissioner of the planned distribution

359.1 or transfer. Upon receipt of notification, the commissioner shall review the distribution or
 359.2 transfer to determine whether the distribution or transfer is reasonable in relation to the
 359.3 health maintenance organization's outstanding liabilities and the quality of the health
 359.4 maintenance organization's earnings and the extent to which the reported earnings include
 359.5 items such as surplus relief reinsurance transactions and reserve restrengthening, and in
 359.6 consideration of the factors described in section 60D.20, subdivision 4. No distribution or
 359.7 transfer shall be made by the health maintenance organization until: (1) 30 days after the
 359.8 commissioner has received notice and has not within this time period disapproved the
 359.9 distribution or transfer; or (2) the commissioner has approved the distribution or transfer
 359.10 within the 30-day period.

359.11 (d) For purposes of this subdivision, "affiliate" means an entity that controls, is controlled
 359.12 by, or is under common control with the health maintenance organization including a
 359.13 nonprofit hospital that is within the same integrated health care system as the health
 359.14 maintenance organization.

359.15 (e) The commissioner of health shall enforce this subdivision.

359.16 Sec. 3. Minnesota Statutes 2018, section 62K.07, is amended to read:

359.17 **62K.07 INFORMATION DISCLOSURES.**

359.18 Subdivision 1. **In general.** (a) A health carrier offering individual or small group health
 359.19 plans must submit the following information in a format determined by the commissioner
 359.20 of commerce:

359.21 (1) claims payment policies and practices;

359.22 (2) periodic financial disclosures;

359.23 (3) data on enrollment;

359.24 (4) data on disenrollment;

359.25 (5) data on the number of claims that are denied;

359.26 (6) data on rating practices;

359.27 (7) information on cost-sharing and payments with respect to out-of-network coverage;

359.28 and

359.29 (8) other information required by the secretary of the United States Department of Health

359.30 and Human Services under the Affordable Care Act.

360.1 (b) A health carrier offering an individual or small group health plan must comply with
 360.2 all information disclosure requirements of all applicable state and federal law, including
 360.3 the Affordable Care Act.

360.4 (c) Except for qualified health plans sold on MNsure, information reported under
 360.5 paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02,
 360.6 subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be
 360.7 reported by MNsure for qualified health plans sold through MNsure.

360.8 Subd. 2. Prescription drug costs. (a) Each health carrier that offers a prescription drug
 360.9 benefit in its individual health plans or small group health plans shall include in the applicable
 360.10 rate filing required under section 62A.02 the following information about covered prescription
 360.11 drugs:

360.12 (1) the 25 most frequently prescribed drugs in the previous plan year;

360.13 (2) the 25 most costly prescription drugs as a portion of the individual health plan's or
 360.14 small group health plan's total annual expenditures in the previous plan year;

360.15 (3) the 25 prescription drugs that have caused the greatest increase in total individual
 360.16 health plan or small group health plan spending in the previous plan year;

360.17 (4) the projected impact of the cost of prescription drugs on premium rates;

360.18 (5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing
 360.19 on any covered prescription drugs including deductibles, co-payments, or coinsurance in
 360.20 an amount that is greater than the amount the enrollee's health plan would pay for the drug
 360.21 absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

360.22 (6) if the health carrier prohibits third-party payments including manufacturer drug
 360.23 discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements
 360.24 including deductibles, co-payments, or coinsurance from applying toward the enrollee's
 360.25 cost-sharing obligations under the enrollee's health plan.

360.26 (b) The commissioner of commerce, in consultation with the commissioner of health,
 360.27 shall release a summary of the information reported in paragraph (a) at the same time as
 360.28 the information required under section 62A.02, subdivision 2, paragraph (c).

360.29 Subd. 3. Enforcement. ~~(d)~~ The commissioner of commerce shall enforce this section.

360.30 EFFECTIVE DATE. This section is effective for individual health plans and small
 360.31 group health plans offered, issued, sold, or renewed on or after January 1, 2021.

361.1 Sec. 4. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to
361.2 read:

361.3 Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment
361.4 limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other
361.5 factors that are not expressed numerically, but otherwise limit the scope or duration of
361.6 benefits for treatment. NQTLs include but are not limited to:

361.7 (1) medical management standards limiting or excluding benefits based on (i) medical
361.8 necessity or medical appropriateness, or (ii) whether the treatment is experimental or
361.9 investigative;

361.10 (2) formulary design for prescription drugs;

361.11 (3) health plans with multiple network tiers;

361.12 (4) criteria and parameters for provider inclusion in provider networks, including
361.13 credentialing standards and reimbursement rates;

361.14 (5) health plan methods for determining usual, customary, and reasonable charges;

361.15 (6) fail-first or step therapy protocols;

361.16 (7) exclusions based on failure to complete a course of treatment;

361.17 (8) restrictions based on geographic location, facility type, provider specialty, and other
361.18 criteria that limit the scope or duration of benefits for services provided under the health
361.19 plan;

361.20 (9) in- and out-of-network geographic limitations;

361.21 (10) standards for providing access to out-of-network providers;

361.22 (11) limitations on inpatient services for situations where the enrollee is a threat to self
361.23 or others;

361.24 (12) exclusions for court-ordered and involuntary holds;

361.25 (13) experimental treatment limitations;

361.26 (14) service coding;

361.27 (15) exclusions for services provided by clinical social workers; and

361.28 (16) provider reimbursement rates, including rates of reimbursement for mental health
361.29 and substance use disorder services in primary care.

362.1 Sec. 5. Minnesota Statutes 2018, section 62Q.47, is amended to read:

362.2 **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY**
362.3 **SERVICES.**

362.4 (a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism,
362.5 mental health, or chemical dependency services, must comply with the requirements of this
362.6 section.

362.7 (b) Cost-sharing requirements and benefit or service limitations for outpatient mental
362.8 health and outpatient chemical dependency and alcoholism services, except for persons
362.9 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to
362.10 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more
362.11 restrictive than those requirements and limitations for outpatient medical services.

362.12 (c) Cost-sharing requirements and benefit or service limitations for inpatient hospital
362.13 mental health and inpatient hospital and residential chemical dependency and alcoholism
362.14 services, except for persons placed in chemical dependency services under Minnesota Rules,
362.15 parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or
362.16 enrollee, or be more restrictive than those requirements and limitations for inpatient hospital
362.17 medical services.

362.18 (d) A health plan company must not impose an NQTL with respect to mental health and
362.19 substance use disorders in any classification of benefits unless, under the terms of the health
362.20 plan as written and in operation, any processes, strategies, evidentiary standards, or other
362.21 factors used in applying the NQTL to mental health and substance use disorders in the
362.22 classification are comparable to, and are applied no more stringently than, the processes,
362.23 strategies, evidentiary standards, or other factors used in applying the NQTL with respect
362.24 to medical and surgical benefits in the same classification.

362.25 ~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity
362.26 Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity
362.27 and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and
362.28 federal guidance or regulations issued under, those acts.

362.29 (f) The commissioner may require information from health plan companies to confirm
362.30 that mental health parity is being implemented by the health plan company. Information
362.31 required may include comparisons between mental health and substance use disorder
362.32 treatment and other medical conditions, including a comparison of prior authorization
362.33 requirements, drug formulary design, claim denials, rehabilitation services, and other
362.34 information the commissioner deems appropriate.

363.1 (g) Regardless of the health care provider's professional license, if the service provided
363.2 is consistent with the provider's scope of practice and the health plan company's credentialing
363.3 and contracting provisions, mental health therapy visits and medication maintenance visits
363.4 shall be considered primary care visits for the purpose of applying any enrollee cost-sharing
363.5 requirements imposed under the enrollee's health plan.

363.6 (h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in
363.7 consultation with the commissioner of health, shall submit a report on compliance and
363.8 oversight to the chairs and ranking minority members of the legislative committees with
363.9 jurisdiction over health and commerce. The report must:

363.10 (1) describe the commissioner's process for reviewing health plan company compliance
363.11 with United States Code, title 42, section 18031(j), any federal regulations or guidance
363.12 relating to compliance and oversight, and compliance with this section and section 62Q.53;

363.13 (2) identify any enforcement actions taken by either commissioner during the preceding
363.14 12-month period regarding compliance with parity for mental health and substance use
363.15 disorders benefits under state and federal law, summarizing the results of any market conduct
363.16 examinations. The summary must include: (i) the number of formal enforcement actions
363.17 taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the
363.18 subject matter of each enforcement action, including quantitative and nonquantitative
363.19 treatment limitations;

363.20 (3) detail any corrective action taken by either commissioner to ensure health plan
363.21 company compliance with this section and section 62Q.53, and United States Code, title
363.22 42, section 18031(j); and

363.23 (4) describe the information provided by either commissioner to the public about
363.24 alcoholism, mental health, or chemical dependency parity protections under state and federal
363.25 law.

363.26 The report must be written in nontechnical, readily understandable language and must be
363.27 made available to the public by, among other means as the commissioners find appropriate,
363.28 posting the report on department websites. Individually identifiable information must be
363.29 excluded from the report, consistent with state and federal privacy protections.

363.30 **Sec. 6. [62Q.528] DRUG COVERAGE IN EMERGENCY SITUATIONS.**

363.31 A health plan that provides prescription drug coverage must provide coverage for a
363.32 prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under

364.1 the terms of coverage that would apply had the prescription drug been dispensed according
364.2 to a prescription.

364.3 Sec. 7. Minnesota Statutes 2018, section 525A.11, is amended to read:

364.4 **525A.11 PERSONS THAT MAY RECEIVE ANATOMICAL GIFT; PURPOSE**
364.5 **OF ANATOMICAL GIFT.**

364.6 (a) An anatomical gift may be made to the following persons named in the document
364.7 of gift:

364.8 (1) a hospital; accredited medical school, dental school, college, or university; organ
364.9 procurement organization; or nonprofit organization in medical education or research, for
364.10 research or education;

364.11 (2) subject to paragraph (b), an individual designated by the person making the anatomical
364.12 gift if the individual is the recipient of the part; and

364.13 (3) an eye bank or tissue bank.

364.14 (b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be
364.15 transplanted into the individual, the part passes in accordance with paragraph (g) in the
364.16 absence of an express, contrary indication by the person making the anatomical gift.

364.17 (c) If an anatomical gift of one or more specific parts or of all parts is made in a document
364.18 of gift that does not name a person described in paragraph (a) but identifies the purpose for
364.19 which an anatomical gift may be used, the following rules apply:

364.20 (1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the
364.21 gift passes to the appropriate eye bank;

364.22 (2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the
364.23 gift passes to the appropriate tissue bank;

364.24 (3) if the part is an organ and the gift is for the purpose of transplantation or therapy,
364.25 the gift passes to the appropriate organ procurement organization as custodian of the organ;
364.26 and

364.27 (4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research or
364.28 education, the gift passes to the appropriate procurement organization.

364.29 (d) For the purpose of paragraph (c), if there is more than one purpose of an anatomical
364.30 gift set forth in the document of gift but the purposes are not set forth in any priority, the

365.1 gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for
365.2 transplantation or therapy, the gift may be used for research or education.

365.3 (e) If an anatomical gift of one or more specific parts is made in a document of gift that
365.4 does not name a person described in paragraph (a) and does not identify the purpose of the
365.5 gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance
365.6 with paragraph (g).

365.7 (f) If a document of gift specifies only a general intent to make an anatomical gift by
365.8 words such as "donor," "organ donor," or "body donor," or by a symbol or statement of
365.9 similar import, the gift may be used only for transplantation or therapy, and the gift passes
365.10 in accordance with paragraph (g).

365.11 (g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

365.12 (1) if the part is an eye, the gift passes to the appropriate eye bank;

365.13 (2) if the part is tissue, the gift passes to the appropriate tissue bank; and

365.14 (3) if the part is an organ, the gift passes to the appropriate organ procurement
365.15 organization as custodian of the organ.

365.16 (h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical
365.17 gift under paragraph (a), clause (2), passes to the organ procurement organization as custodian
365.18 of the organ.

365.19 (i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the decedent's
365.20 body or part is not used for transplantation, therapy, research, or education, custody of the
365.21 body or part passes to the person under obligation to dispose of the body or part.

365.22 (j) A person may not accept an anatomical gift if the person knows that the gift was not
365.23 effectively made under section 525A.05 or 525A.10 or if the person knows that the decedent
365.24 made a refusal under section 525A.07 that was not revoked. For purposes of this paragraph,
365.25 if a person knows that an anatomical gift was made on a document of gift, the person is
365.26 deemed to know of any amendment or revocation of the gift or any refusal to make an
365.27 anatomical gift on the same document of gift.

365.28 (k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter
365.29 affects the allocation of organs for transplantation or therapy.

365.30 (l) For purposes of paragraphs (c), clauses (1) and (4), and (g), no gift of an eye or a part
365.31 of an eye shall be directly or indirectly processed by or distributed to a for profit entity, and
365.32 no gift shall be sold or distributed for profit.

366.1

ARTICLE 13

366.2

FORECAST ADJUSTMENT

366.3

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

366.4

The dollar amounts shown in the columns marked "Appropriations" are added to or, if

366.5

shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special

366.6

Session chapter 6, article 18, from the general fund, or any other fund named, to the

366.7

commissioner of human services for the purposes specified in this article, to be available

366.8

for the fiscal year indicated for each purpose. The figure "2019" used in this article means

366.9

that the appropriations listed are available for the fiscal year ending June 30, 2019.

366.10

APPROPRIATIONS

366.11

Available for the Year

366.12

Ending June 30

366.13

2019

366.14

Sec. 2. **COMMISSIONER OF HUMAN**

366.15

SERVICES

366.16

Subdivision 1. Total Appropriation**\$****(318,423,000)**

366.17

Appropriations by Fund

366.18

2019

366.19

General**(317,538,000)**

366.20

Health Care Access**8,410,000**

366.21

Federal TANF**(9,295,000)**

366.22

Subd. 2. Forecasted Programs

366.23

(a) Minnesota Family

366.24

Investment Program

366.25

(MFIP)/Diversionary Work

366.26

Program (DWP)

366.27

Appropriations by Fund

366.28

General**(19,361,000)**

366.29

Federal TANF**(8,893,000)**

366.30

(b) MFIP Child Care Assistance**(16,789,000)**

366.31

(c) General Assistance**(7,928,000)**

366.32

(d) Minnesota Supplemental Aid**(549,000)**

366.33

(e) Housing Support**(13,836,000)**

366.34

(f) Northstar Care for Children**(19,027,000)**

367.1 (g) MinnesotaCare 8,410,000

367.2 This appropriation is from the health care
367.3 access fund.

367.4 (h) Medical Assistance

367.5 Appropriations by Fund

367.6 General (222,176,000)

367.7 Health Care Access -0-

367.8 (i) Alternative Care -0-

367.9 (j) Consolidated Chemical Dependency
367.10 Treatment Fund (CCDTF) Entitlement (17,872,000)

367.11 Subd. 3. Technical Activities (402,000)

367.12 This appropriation is from the federal TANF
367.13 fund.

367.14 Sec. 3. EFFECTIVE DATE.

367.15 Sections 1 and 2 are effective the day following final enactment.

367.16 **ARTICLE 14**

367.17 **APPROPRIATIONS**

367.18 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

367.19 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
367.20 and for the purposes specified in this article. The appropriations are from the general fund,
367.21 or another named fund, and are available for the fiscal years indicated for each purpose.

367.22 The figures "2020" and "2021" used in this article mean that the appropriations listed under
367.23 them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively.

367.24 "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium"
367.25 is fiscal years 2020 and 2021.

367.26 **APPROPRIATIONS**

367.27 **Available for the Year**

367.28 **Ending June 30**

367.29 **2020** **2021**

- 369.1 (3) state and county MFIP administrative costs
369.2 under Minnesota Statutes, chapters 256J and
369.3 256K;
- 369.4 (4) state, county, and tribal MFIP employment
369.5 services under Minnesota Statutes, chapters
369.6 256J and 256K;
- 369.7 (5) expenditures made on behalf of legal
369.8 noncitizen MFIP recipients who qualify for
369.9 the MinnesotaCare program under Minnesota
369.10 Statutes, chapter 256L;
- 369.11 (6) qualifying working family credit
369.12 expenditures under Minnesota Statutes, section
369.13 290.0671;
- 369.14 (7) qualifying Minnesota education credit
369.15 expenditures under Minnesota Statutes, section
369.16 290.0674; and
- 369.17 (8) qualifying Head Start expenditures under
369.18 Minnesota Statutes, section 119A.50.
- 369.19 **(b) Nonfederal Expenditures; Reporting.**
369.20 For the activities listed in paragraph (a),
369.21 clauses (2) to (8), the commissioner may
369.22 report only expenditures that are excluded
369.23 from the definition of assistance under Code
369.24 of Federal Regulations, title 45, section
369.25 260.31.
- 369.26 **(c) Maintenance of Effort Expenditures**
369.27 **Required.** The commissioner shall ensure that
369.28 the MOE used by the commissioner of
369.29 management and budget for the February and
369.30 November forecasts required under Minnesota
369.31 Statutes, section 16A.103, contains
369.32 expenditures under paragraph (a), clause (1),
369.33 equal to at least 16 percent of the total required

370.1 under Code of Federal Regulations, title 45,
370.2 section 263.1.

370.3 **(d) Limitation; Exceptions.** The
370.4 commissioner must not claim an amount of
370.5 TANF/MOE in excess of the 75 percent
370.6 standard in Code of Federal Regulations, title
370.7 45, section 263.1(a)(2), except:

370.8 (1) to the extent necessary to meet the 80
370.9 percent standard under Code of Federal
370.10 Regulations, title 45, section 263.1(a)(1), if it
370.11 is determined by the commissioner that the
370.12 state will not meet the TANF work
370.13 participation target rate for the current year;

370.14 (2) to provide any additional amounts under
370.15 Code of Federal Regulations, title 45, section
370.16 264.5, that relate to replacement of TANF
370.17 funds due to the operation of TANF penalties;
370.18 and

370.19 (3) to provide any additional amounts that may
370.20 contribute to avoiding or reducing TANF work
370.21 participation penalties through the operation
370.22 of the excess MOE provisions of Code of
370.23 Federal Regulations, title 45, section 261.43
370.24 (a)(2).

370.25 **(e) Supplemental Expenditures.** For the
370.26 purposes of paragraph (d), the commissioner
370.27 may supplement the MOE claim with working
370.28 family credit expenditures or other qualified
370.29 expenditures to the extent such expenditures
370.30 are otherwise available after considering the
370.31 expenditures allowed in this subdivision.

370.32 **(f) Reduction of Appropriations; Exception.**
370.33 The requirement in Minnesota Statutes, section
370.34 256.011, subdivision 3, that federal grants or

371.1 aids secured or obtained under that subdivision
371.2 be used to reduce any direct appropriations
371.3 provided by law, does not apply if the grants
371.4 or aids are federal TANF funds.

371.5 **(g) IT Appropriations Generally.** This
371.6 appropriation includes funds for information
371.7 technology projects, services, and support.
371.8 Notwithstanding Minnesota Statutes, section
371.9 16E.0466, funding for information technology
371.10 project costs shall be incorporated into the
371.11 service level agreement and paid to the Office
371.12 of MN.IT Services by the Department of
371.13 Human Services under the rates and
371.14 mechanism specified in that agreement.

371.15 **(h) Receipts for Systems Project.**
371.16 Appropriations and federal receipts for
371.17 information systems projects for MAXIS,
371.18 PRISM, MMIS, ISDS, METS, and SSIS must
371.19 be deposited in the state systems account
371.20 authorized in Minnesota Statutes, section
371.21 256.014. Any unexpended balance in the
371.22 appropriations for these projects does not
371.23 cancel and is available for ongoing
371.24 development and operations.

371.25 **(i) Federal SNAP Education and Training**
371.26 **Grants.** Federal funds available during fiscal
371.27 years 2020 and 2021 for Supplemental
371.28 Nutrition Assistance Program Education and
371.29 Training and SNAP Quality Control
371.30 Performance Bonus grants are appropriated
371.31 to the commissioner of human services for the
371.32 purposes allowable under the terms of the
371.33 federal award. This paragraph is effective the
371.34 day following final enactment.

372.1 Subd. 3. Working Family Credit as TANF/MOE.372.2 The commissioner may claim as TANF/MOE372.3 up to \$6,707,000 per year of working family372.4 credit expenditures in each fiscal year.372.5 Subd. 4. Central Office; Operations372.6 Appropriations by Fund372.7 General 120,177,000 118,098,000372.8 State Government372.9 Special Revenue 4,174,000 4,174,000372.10 Health Care Access 20,709,000 20,709,000372.11 Federal TANF 100,000 100,000372.12 (a) Administrative Recovery; Set-Aside. The372.13 commissioner may invoice local entities372.14 through the SWIFT accounting system as an372.15 alternative means to recover the actual cost of372.16 administering the following provisions:372.17 (1) the statewide data management system372.18 authorized in Minnesota Statutes, section372.19 125A.744, subdivision 3;372.20 (2) repayment of the special revenue372.21 maximization account as provided under372.22 Minnesota Statutes, section 245.495,372.23 paragraph (b);372.24 (3) repayment of the special revenue372.25 maximization account as provided under372.26 Minnesota Statutes, section 256B.0625,372.27 subdivision 20, paragraph (k);372.28 (4) targeted case management under372.29 Minnesota Statutes, section 256B.0924,372.30 subdivision 6, paragraph (g);372.31 (5) residential services for children with severe372.32 emotional disturbance under Minnesota372.33 Statutes, section 256B.0945, subdivision 4,372.34 paragraph (d); and

- 373.1 (6) repayment of the special revenue
373.2 maximization account as provided under
373.3 Minnesota Statutes, section 256F.10,
373.4 subdivision 6, paragraph (b).
- 373.5 **(b) Transfer; Systems Account.** By June 30,
373.6 2021, the commissioner shall transfer
373.7 \$17,718,000 from the state systems account
373.8 authorized in Minnesota Statutes, section
373.9 256.014, subdivision 2, to the general fund.
373.10 This is a onetime transfer.
- 373.11 **(c) Transfer; Medical Assistance Holding**
373.12 **Account.** By June 30, 2021, the commissioner
373.13 shall transfer \$2,600,000 from the medical
373.14 assistance holding account under Minnesota
373.15 Statutes, section 256.01, subdivision 2, to the
373.16 general fund. This is a onetime transfer.
- 373.17 **(d) Transfer; SSI Interim Assistance**
373.18 **Operations Account.** By June 30, 2021, the
373.19 commissioner shall transfer \$3,600,000 from
373.20 the SSI interim assistance operations account
373.21 under Minnesota Statutes, section 256D.06,
373.22 subdivision 5, paragraph (e), to the general
373.23 fund. This is a onetime transfer.
- 373.24 **(e) Transfer to Office of Legislative Auditor.**
373.25 \$300,000 in fiscal year 2020 and \$300,000 in
373.26 fiscal year 2021 are from the general fund for
373.27 transfer to the Office of the Legislative
373.28 Auditor for audit activities under Minnesota
373.29 Statutes, section 3.972, subdivision 2b.
- 373.30 **(f) Transfer to Office of Legislative Auditor.**
373.31 \$400,000 in fiscal year 2020 and \$400,000 in
373.32 fiscal year 2021 are from the general fund for
373.33 transfer to the Office of the Legislative

374.1 Auditor for audit activities under Minnesota
374.2 Statutes, section 3.972, subdivision 2a.

374.3 **(g) Fraud Prevention Investigations.**
374.4 \$425,000 in fiscal year 2020 and \$425,000 in
374.5 fiscal year 2021 are from the general fund for
374.6 the fraud prevention investigation project
374.7 under Minnesota Statutes, section 256.983.

374.8 **(h) Family Child Care Task Force. \$75,000**
374.9 in fiscal year 2020 is from the general fund
374.10 for the Family Child Care Task Force under
374.11 article 2, section 45. This is a onetime
374.12 appropriation.

374.13 **(i) Ombudsperson for Child Care**
374.14 **Providers. \$114,000 in fiscal year 2020 and**
374.15 **\$120,000 in fiscal year 2021 are from the**
374.16 **general fund for the ombudsperson for child**
374.17 **care providers under Minnesota Statutes,**
374.18 **section 245A.60.**

374.19 **(j) Development of New Child Care**
374.20 **Regulatory System. \$409,000 in fiscal year**
374.21 **2020 is from the general fund for development**
374.22 **of a new child care regulatory system based**
374.23 **on the risk-based violation levels under**
374.24 **Minnesota Statutes, section 245A.055,**
374.25 **subdivision 3, including use of an abbreviated**
374.26 **inspection under Minnesota Statutes, section**
374.27 **245A.055, subdivision 2. Of this amount,**
374.28 **\$300,000 is for researching and developing**
374.29 **the abbreviated inspection model based on key**
374.30 **indicators, and \$109,000 is to update the**
374.31 **Electronic Licensing Inspection Checklist**
374.32 **Information (ELICI) system. This is a onetime**
374.33 **appropriation.**

375.1 **(k) Reducing Appropriations for Unfilled**
 375.2 **Positions.** The general fund and nongeneral
 375.3 fund appropriations to the Department of
 375.4 Human Services for agency operations for the
 375.5 biennium ending June 30, 2021, are reduced
 375.6 for salary and benefit amounts attributable to
 375.7 any positions that are not filled within 180
 375.8 days of the posting of the position. This
 375.9 paragraph applies only to positions that are
 375.10 posted in fiscal years 2019, 2020, and 2021.
 375.11 Reductions made under this section must be
 375.12 reflected as reductions in agency base budgets
 375.13 for fiscal years 2022 and 2023. The
 375.14 commissioner of management and budget must
 375.15 report to the chairs and ranking minority
 375.16 members of the senate and the house of
 375.17 representatives health and human services
 375.18 finance committees regarding the amount of
 375.19 reductions in appropriations under this section.
 375.20 This paragraph expires December 31, 2021.

375.21 **(l) Base Level Adjustment.** The general fund
 375.22 base is \$120,223,000 in fiscal year 2022 and
 375.23 \$122,712,000 in fiscal year 2023.

375.24 **Subd. 5. Central Office; Children and Families**

375.25	<u>Appropriations by Fund</u>	
375.26	<u>General</u>	<u>10,818,000</u> <u>10,787,000</u>
375.27	<u>Federal TANF</u>	<u>2,582,000</u> <u>2,582,000</u>

375.28 **(a) Financial Institution Data Match and**
 375.29 **Payment of Fees.** The commissioner is
 375.30 authorized to allocate up to \$310,000 each
 375.31 year in fiscal year 2020 and fiscal year 2021
 375.32 from the state systems account authorized in
 375.33 Minnesota Statutes, section 256.014,
 375.34 subdivision 2, to make payments to financial
 375.35 institutions in exchange for performing data

376.1 matches between account information held by
 376.2 financial institutions and the public authority's
 376.3 database of child support obligors as
 376.4 authorized by Minnesota Statutes, section
 376.5 13B.06, subdivision 7.

376.6 **(b) Base Level Adjustment.** The general fund
 376.7 base is \$10,733,000 in fiscal year 2022 and
 376.8 \$10,680,000 in fiscal year 2023.

376.9 **Subd. 6. Central Office; Health Care**

	<u>Appropriations by Fund</u>	
376.11 <u>General</u>	<u>23,099,000</u>	<u>23,702,000</u>
376.12 <u>Health Care Access</u>	<u>24,313,000</u>	<u>24,313,000</u>

376.13 **Base Level Adjustment.** The general fund
 376.14 base is \$24,088,000 in fiscal year 2022 and
 376.15 \$24,074,000 in fiscal year 2023.

376.16 **Subd. 7. Central Office; Continuing Care for**
 376.17 **Older Adults**

	<u>Appropriations by Fund</u>	
376.19 <u>General</u>	<u>16,259,000</u>	<u>16,434,000</u>
376.20 <u>State Government</u>		
376.21 <u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

376.22 **Office of Ombudsman for Long-Term Care.**
 376.23 \$1,312,000 in fiscal year 2020 and \$1,501,000
 376.24 in fiscal year 2021 are from the general fund
 376.25 for nine additional regional ombudsmen and
 376.26 one deputy director in the Office of
 376.27 Ombudsman for Long-Term Care, to perform
 376.28 the duties in Minnesota Statutes, section
 376.29 256.9742.

376.30 **Subd. 8. Central Office; Community Supports**

	<u>Appropriations by Fund</u>	
376.32 <u>General</u>	<u>34,558,000</u>	<u>34,168,000</u>
376.33 <u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>

377.1 **(a) Social Functioning Measurement Tool.**
 377.2 \$100,000 in fiscal year 2020 is from the
 377.3 general fund for the commissioner to
 377.4 determine whether the Center for Victims of
 377.5 Torture's social functioning measurement tool
 377.6 can be adapted for other populations that
 377.7 receive targeted case management and other
 377.8 medical assistance services. This is a onetime
 377.9 appropriation and is available until June 30,
 377.10 2023.

377.11 **(b) Person-Centered Telepresence Platform**
 377.12 **Expansion.** \$100,000 in fiscal year 2020 is
 377.13 from the general fund for development of a
 377.14 proposal to expand and implement a statewide
 377.15 person-centered telepresence platform. This
 377.16 is a onetime appropriation.

377.17 **(c) Base Level Adjustment.** The general fund
 377.18 base is \$34,483,000 in fiscal year 2022 and
 377.19 \$34,085,000 in fiscal year 2023.

377.20 **Subd. 9. Forecasted Programs; MFIP/DWP**

	<u>Appropriations by Fund</u>	
377.21		
377.22	<u>General</u>	<u>79,959,000</u> <u>80,738,000</u>
377.23	<u>Federal TANF</u>	<u>75,607,000</u> <u>76,851,000</u>

377.24 **Subd. 10. Forecasted Programs; MFIP Child**
 377.25 **Care Assistance**

	<u>105,380,000</u>	<u>-0-</u>
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377.26 **Subd. 11. Forecasted Programs; General**
 377.27 **Assistance**

	<u>49,791,000</u>	<u>50,308,000</u>
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377.28 **(a) General Assistance Standard.** The
 377.29 commissioner shall set the monthly standard
 377.30 of assistance for general assistance units
 377.31 consisting of an adult recipient who is
 377.32 childless and unmarried or living apart from
 377.33 parents or a legal guardian at \$203. The
 377.34 commissioner may reduce this amount

378.1 according to Laws 1997, chapter 85, article 3,
 378.2 section 54.

378.3 **(b) Emergency General Assistance Limit.**

378.4 The amount appropriated for emergency
 378.5 general assistance is limited to no more than
 378.6 \$6,729,812 in fiscal year 2020 and \$6,729,812
 378.7 in fiscal year 2021. Funds to counties shall be
 378.8 allocated by the commissioner using the
 378.9 allocation method under Minnesota Statutes,
 378.10 section 256D.06.

378.11 **Subd. 12. Forecasted Programs; Minnesota**
 378.12 **Supplemental Aid**

42,271,000

45,860,000

378.13 **Subd. 13. Forecasted Programs; Housing**
 378.14 **Support**

167,680,000

170,253,000

378.15 **Subd. 14. Forecasted Programs; Northstar Care**
 378.16 **for Children**

86,497,000

94,095,000

378.17 **Subd. 15. Forecasted Programs; MinnesotaCare**

25,100,000

27,665,000

378.18 This appropriation is from the health care
 378.19 access fund.

378.20 **Subd. 16. Forecasted Programs; Medical**
 378.21 **Assistance**

378.22 Appropriations by Fund

378.23 General 5,610,367,000 5,616,974,000

378.24 Health Care Access 439,598,000 439,598,000

378.25 **(a) Behavioral Health Services. \$1,000,000**

378.26 in fiscal year 2020 and \$1,000,000 in fiscal
 378.27 year 2021 are for behavioral health services
 378.28 provided by hospitals identified under
 378.29 Minnesota Statutes, section 256.969,
 378.30 subdivision 2b, paragraph (a), clause (4). The
 378.31 increase in payments shall be made by
 378.32 increasing the adjustment under Minnesota
 378.33 Statutes, section 256.969, subdivision 2b,
 378.34 paragraph (e), clause (2).

379.1	<u>(b) Base Level Adjustment. The health care</u>		
379.2	<u>access fund base is \$439,598,000 in fiscal year</u>		
379.3	<u>2022 and \$439,598,000 in fiscal year 2023.</u>		
379.4	<u>Subd. 17. Forecasted Programs; Alternative</u>		
379.5	<u>Care</u>	<u>45,135,000</u>	<u>45,154,000</u>
379.6	<u>Alternative Care Transfer. Any money</u>		
379.7	<u>allocated to the alternative care program that</u>		
379.8	<u>is not spent for the purposes indicated does</u>		
379.9	<u>not cancel but must be transferred to the</u>		
379.10	<u>medical assistance account.</u>		
379.11	<u>Subd. 18. Forecasted Programs; Chemical</u>		
379.12	<u>Dependency Treatment Fund</u>	<u>127,503,000</u>	<u>131,750,000</u>
379.13	<u>Transfer; Consolidated Chemical</u>		
379.14	<u>Dependency Treatment Fund. Any balance</u>		
379.15	<u>remaining in the consolidated chemical</u>		
379.16	<u>dependency treatment fund at the end of fiscal</u>		
379.17	<u>year 2020, estimated to be \$23,855,000, shall</u>		
379.18	<u>be transferred to the general fund.</u>		
379.19	<u>Subd. 19. Grant Programs; Support Services</u>		
379.20	<u>Grants</u>		
379.21	<u>Appropriations by Fund</u>		
379.22	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
379.23	<u>Federal TANF</u>	<u>96,312,000</u>	<u>96,311,000</u>
379.24	<u>Subd. 20. Grant Programs; Basic Sliding Fee</u>		
379.25	<u>Child Care Assistance Grants</u>	<u>44,655,000</u>	<u>-0-</u>
379.26	<u>Base Level Adjustment. The general fund</u>		
379.27	<u>base is \$236,264,000 in fiscal year 2022 and</u>		
379.28	<u>zero in fiscal year 2023.</u>		
379.29	<u>Subd. 21. Grant Programs; Child Care</u>		
379.30	<u>Development Grants</u>	<u>1,737,000</u>	<u>1,737,000</u>
379.31	<u>Subd. 22. Grant Programs; Child Support</u>		
379.32	<u>Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
379.33	<u>Subd. 23. Grant Programs; Children's Services</u>		
379.34	<u>Grants</u>		

380.1	<u>Appropriations by Fund</u>		
380.2	<u>General</u>	<u>39,165,000</u>	<u>39,165,000</u>
380.3	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
380.4	<u>Title IV-E Adoption Assistance.</u> The		
380.5	<u>commissioner shall allocate funds from the</u>		
380.6	<u>Title IV-E reimbursement to the state from</u>		
380.7	<u>the Fostering Connections to Success and</u>		
380.8	<u>Increasing Adoptions Act for adoptive, foster,</u>		
380.9	<u>and kinship families as required in Minnesota</u>		
380.10	<u>Statutes, section 256N.261.</u>		
380.11	<u>Additional federal reimbursement to the state</u>		
380.12	<u>as a result of the Fostering Connections to</u>		
380.13	<u>Success and Increasing Adoptions Act's</u>		
380.14	<u>expanded eligibility for title IV-E adoption</u>		
380.15	<u>assistance is for postadoption, foster care,</u>		
380.16	<u>adoption, and kinship services, including a</u>		
380.17	<u>parent-to-parent support network.</u>		
380.18	<u>Subd. 24. Grant Programs; Children and</u>		
380.19	<u>Community Service Grants</u>	<u>58,201,000</u>	<u>58,201,000</u>
380.20	<u>Subd. 25. Grant Programs; Children and</u>		
380.21	<u>Economic Support Grants</u>		
380.22	<u>Appropriations by Fund</u>		
380.23	<u>General</u>	<u>22,665,000</u>	<u>22,065,000</u>
380.24	<u>Federal TANF</u>	<u>-0-</u>	<u>1,000,000</u>
380.25	<u>(a) Minnesota Food Assistance Program.</u>		
380.26	<u>Unexpended funds for the Minnesota food</u>		
380.27	<u>assistance program for fiscal year 2020 do not</u>		
380.28	<u>cancel but are available for this purpose in</u>		
380.29	<u>fiscal year 2021.</u>		
380.30	<u>(b) Pathways to Prosperity.</u> \$1,000,000 in		
380.31	<u>fiscal year 2021 is from the federal TANF</u>		
380.32	<u>fund for the unified benefit amount of the</u>		
380.33	<u>Minnesota Pathways to Prosperity and</u>		
380.34	<u>Well-Being pilot project. The commissioner</u>		
380.35	<u>shall award the grant only upon issuance of</u>		

381.1 formal approval of the pilot project plan as
 381.2 required under article 2, section 39,
 381.3 subdivision 1, paragraph (c), and after
 381.4 fulfillment of the condition in article 2, section
 381.5 39, subdivision 1, paragraph (b), clause (3).
 381.6 No amount of the appropriation may be used
 381.7 for any other purpose of the pilot project. The
 381.8 base for this appropriation is \$1,000,000 in
 381.9 fiscal year 2022 and \$1,000,000 in fiscal year
 381.10 2023. This is not an ongoing appropriation.
 381.11 The commissioner of management and budget
 381.12 shall not include a base amount for this
 381.13 appropriation in fiscal year 2024. This section
 381.14 expires June 30, 2023.

381.15 **(c) Homeless Youth Drop-In Program**
 381.16 **Grant.** Notwithstanding Minnesota Statutes,
 381.17 section 16B.97, \$100,000 in fiscal year 2020
 381.18 is from the general fund for a grant to an
 381.19 organization in Anoka County providing
 381.20 services and programming through a drop-in
 381.21 program to meet the basic needs, including
 381.22 mental health needs, of homeless youth in the
 381.23 north metropolitan suburbs, to develop a
 381.24 model of its homeless youth drop-in program
 381.25 that can be shared and replicated in other
 381.26 communities throughout Minnesota. This is a
 381.27 onetime appropriation.

381.28 **(d) Shelter-Linked Youth Mental Health**
 381.29 **Grants.** \$500,000 in fiscal year 2020 is from
 381.30 the general fund for shelter-linked youth
 381.31 mental health grants under Minnesota Statutes,
 381.32 section 256K.46. This is a onetime
 381.33 appropriation and is available until June 30,
 381.34 2023. This paragraph expires July 1, 2023.

381.35 **Subd. 26. Grant Programs; Health Care Grants**

382.1	<u>Appropriations by Fund</u>		
382.2	<u>General</u>	<u>3,711,000</u>	<u>3,711,000</u>
382.3	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>
382.4	<u>Subd. 27. Grant Programs; Other Long-Term</u>		
382.5	<u>Care Grants</u>	<u>1,925,000</u>	<u>1,925,000</u>
382.6	<u>Subd. 28. Grant Programs; Aging and Adult</u>		
382.7	<u>Services Grants</u>	<u>32,811,000</u>	<u>32,995,000</u>
382.8	<u>Subd. 29. Grant Programs; Deaf and</u>		
382.9	<u>Hard-of-Hearing Grants</u>	<u>2,675,000</u>	<u>2,675,000</u>
382.10	<u>Base Level Adjustment.</u> The general fund		
382.11	base is <u>\$2,886,000 in fiscal year 2022 and</u>		
382.12	<u>\$2,886,000 in fiscal year 2023.</u>		
382.13	<u>Subd. 30. Grant Programs; Disabilities Grants</u>	<u>21,995,000</u>	<u>21,996,000</u>
382.14	<u>(a) Semi-Independent Living Services</u>		
382.15	<u>Grants.</u> <u>\$1,000,000 in fiscal year 2020 and</u>		
382.16	<u>\$1,000,000 in fiscal year 2021 are from the</u>		
382.17	<u>general fund for reimbursement to lead</u>		
382.18	<u>agencies under Minnesota Statutes, section</u>		
382.19	<u>252.275.</u>		
382.20	<u>(b) Parent-to-Parent Peer Support Grants.</u>		
382.21	<u>\$100,000 in fiscal year 2020 and \$100,000 in</u>		
382.22	<u>fiscal year 2021 are from the general fund for</u>		
382.23	<u>grants under Minnesota Statutes, section</u>		
382.24	<u>256.4751.</u>		
382.25	<u>(c) Adaptive Fitness Access Grants.</u>		
382.26	<u>\$125,000 in fiscal year 2020 and \$125,000 in</u>		
382.27	<u>fiscal year 2021 are from the general fund for</u>		
382.28	<u>the grant program under Minnesota Statutes,</u>		
382.29	<u>section 256.488.</u>		
382.30	<u>(d) Day Training and Habilitation Disability</u>		
382.31	<u>Waiver Rate System Transition Grants.</u>		
382.32	<u>\$200,000 in fiscal year 2020 and \$200,000 in</u>		
382.33	<u>fiscal year 2021 are from the general fund for</u>		
382.34	<u>day training and habilitation disability waiver</u>		

383.1 rate system transition grants under article 5,
 383.2 section 94.

383.3 **(e) Family Support Grants.** The general fund
 383.4 base for family support grants under
 383.5 Minnesota Statutes, section 252.32, is
 383.6 \$10,278,000 in fiscal year 2022 and
 383.7 \$8,278,000 in fiscal year 2023. The
 383.8 commissioner may use up to \$2,000,000 of
 383.9 the 2022 fiscal year base funding to reimburse
 383.10 counties that issue family support grants in an
 383.11 amount that exceeds the county's allocation in
 383.12 fiscal year 2021.

383.13 **(f) Base Level Adjustment.** The general fund
 383.14 base is \$27,996,000 in fiscal year 2022 and
 383.15 \$25,996,000 in fiscal year 2023.

383.16 **Subd. 31. Grant Programs; Housing Support**
 383.17 **Grants**

9,339,000

10,389,000

383.18 **(a) Community-Based Housing and**
 383.19 **Behavioral Health Services for Opiate**
 383.20 **Addiction.** Notwithstanding Minnesota
 383.21 Statutes, section 16B.97, \$25,000 in fiscal year
 383.22 2020 and \$25,000 in fiscal year 2021 are from
 383.23 the general fund for a grant to Oasis Central
 383.24 Minnesota, Inc., serving Morrison County to
 383.25 provide opioid programming, behavioral
 383.26 health services, and residential housing with
 383.27 employment services.

383.28 **(b) Transitional Housing Program.**
 383.29 Notwithstanding Minnesota Statutes, section
 383.30 16B.97, \$50,000 in fiscal year 2020 is from
 383.31 the general fund for a transitional housing and
 383.32 support program located in Rice County that
 383.33 serves women and children in crisis to enhance
 383.34 current services and supports and to determine
 383.35 if the program's model can be expanded

384.1 statewide. The commissioner of human
 384.2 services shall report by February 1, 2020, to
 384.3 the chairs and ranking minority members of
 384.4 the legislative committees with jurisdiction
 384.5 over transitional housing programs on the
 384.6 outcomes of the program and provide
 384.7 recommendations on expanding the program's
 384.8 model statewide. This is a onetime
 384.9 appropriation.

384.10 **Subd. 32. Grant Programs; Adult Mental Health**
 384.11 **Grants**

86,858,000

82,577,000

384.12 **(a) Taylor Hayden Violence Prevention**
 384.13 **Grants. \$100,000 in fiscal year 2020 is for**
 384.14 **violence prevention grants to nonprofit**
 384.15 **organizations with expertise in violence**
 384.16 **prevention to conduct violence prevention**
 384.17 **initiatives or public awareness and education**
 384.18 **campaigns on violence prevention. This is a**
 384.19 **onetime appropriation.**

384.20 **(b) Project Legacy. \$250,000 in fiscal year**
 384.21 **2020 is for a grant to Project Legacy to**
 384.22 **provide counseling and outreach to youth and**
 384.23 **young adults from families with a history of**
 384.24 **generational poverty. Money from this**
 384.25 **appropriation must be spent for mental health**
 384.26 **care, medical care, chemical dependency**
 384.27 **intervention, housing, and mentoring and**
 384.28 **counseling services for first generation college**
 384.29 **students. This is a onetime appropriation and**
 384.30 **is available until June 30, 2023. This**
 384.31 **paragraph expires July 1, 2023.**

384.32 **(c) Housing Options for Persons with**
 384.33 **Serious Mental Illness. \$2,000,000 in fiscal**
 384.34 **year 2020 is for adult mental health grants**
 384.35 **under Minnesota Statutes, section 245.4661,**

385.1 subdivision 9, paragraph (a), clause (2), to
385.2 increase availability of housing options with
385.3 supports for persons with serious mental
385.4 illness. This is a onetime appropriation and is
385.5 available until June 30, 2023. This paragraph
385.6 expires July 1, 2023.

385.7 **(d) Officer-Involved Community-Based**
385.8 **Care Coordination Grants. \$1,000,000 in**
385.9 **fiscal year 2020 is for officer-involved**
385.10 **community-based care coordination grants.**
385.11 **Of this amount:**

385.12 **(1) \$900,000 is for officer-involved**
385.13 **community-based care coordination grants**
385.14 **under Minnesota Statutes, section 245.4663.**

385.15 **Of this amount, \$500,000 shall be awarded to**
385.16 **Blue Earth county. This is a onetime**
385.17 **appropriation and is available until June 30,**
385.18 **2023; and**

385.19 **(2) \$100,000 is for up to ten planning grants**
385.20 **under article 3, section 38. In awarding these**
385.21 **grants, the commissioner must place a priority**
385.22 **on funding nonmetro programs. This is a**
385.23 **onetime appropriation and is available until**
385.24 **June 30, 2023.**

385.25 **This paragraph expires July 1, 2023.**

385.26 **(e) Mobile Mental Health Crisis Response**
385.27 **Team Funding. \$4,150,000 in fiscal year**
385.28 **2020 and \$4,150,000 in fiscal year 2021 are**
385.29 **for adult mental health grants under Minnesota**
385.30 **Statutes, section 245.4661, subdivision 9,**
385.31 **paragraph (a), clause (1), to fund regional**
385.32 **mobile mental health crisis response teams**
385.33 **throughout the state. This is a onetime**

386.1 appropriation and is available until June 30,
 386.2 2023. This paragraph expires July 1, 2023.

386.3 **(f) Specialized Mental Health Community**
 386.4 **Supervision Pilot Project.** \$200,000 in fiscal
 386.5 year 2020 and \$200,000 in fiscal year 2021
 386.6 are for a grant to Anoka County for
 386.7 establishment of a specialized mental health
 386.8 community supervision caseload pilot project.
 386.9 This is a onetime appropriation.

386.10 **(g) Base Level Adjustment.** The general fund
 386.11 base is \$78,427,000 in fiscal year 2022 and
 386.12 \$78,427,000 in fiscal year 2023.

386.13 **Subd. 33. Grant Programs; Child Mental Health**
 386.14 **Grants**

21,519,000

20,826,000

386.15 **(a) Community-Based Children's Mental**
 386.16 **Health Grant.** Notwithstanding Minnesota
 386.17 Statutes, section 16B.97, \$193,000 in fiscal
 386.18 year 2020 is from the general fund for a grant
 386.19 to the Family Enhancement Center for staffing
 386.20 and administrative support to provide children
 386.21 access to expert mental health services
 386.22 regardless of a child's insurance status or
 386.23 income. This is a onetime appropriation and
 386.24 is available until June 30, 2021.

386.25 **(b) Telemedicine Equipment for**
 386.26 **School-Linked Mental Health Services.**
 386.27 \$500,000 in fiscal year 2020 is for grants to
 386.28 purchase equipment to deliver school-linked
 386.29 mental health services by telemedicine. The
 386.30 grants may be awarded to new or existing
 386.31 providers statewide. The commissioner shall
 386.32 report to the legislative committees with
 386.33 jurisdiction over mental health on the
 386.34 effectiveness of the grants after funds
 386.35 appropriated under this section are expended.

387.1 This is a onetime appropriation and available
 387.2 until June 30, 2023. This paragraph expires
 387.3 July 1, 2023.

387.4 **Subd. 34. Grant Programs; Chemical**
 387.5 **Dependency Treatment Support Grants**

387.6	<u>Appropriations by Fund</u>		
387.7	<u>General</u>	<u>2,386,000</u>	<u>2,386,000</u>
387.8	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

387.9 **(a) Problem Gambling.** \$225,000 in fiscal
 387.10 year 2020 and \$225,000 in fiscal year 2021
 387.11 are from the lottery prize fund for a grant to
 387.12 the state affiliate recognized by the National
 387.13 Council on Problem Gambling. The affiliate
 387.14 must provide services to increase public
 387.15 awareness of problem gambling, education,
 387.16 and training for individuals and organizations
 387.17 providing effective treatment services to
 387.18 problem gamblers and their families, and
 387.19 research related to problem gambling.

387.20 **(b) Fetal Alcohol Spectrum Disorders**
 387.21 **Grants.** \$250,000 in fiscal year 2020 and
 387.22 \$250,000 in fiscal year 2021 are from the
 387.23 general fund for a grant under Minnesota
 387.24 Statutes, section 254A.21, to a statewide
 387.25 organization that focuses solely on prevention
 387.26 of and intervention with fetal alcohol spectrum
 387.27 disorders.

387.28 **Subd. 35. Direct Care and Treatment -**
 387.29 **Generally**

387.30 **Transfer; State-Operated Services Account.**
 387.31 Any balance remaining in the state operated
 387.32 services account at the end of fiscal year 2019,
 387.33 estimated to be \$13,000,000 shall be
 387.34 transferred to the general fund.

388.1	<u>Subd. 36. Direct Care and Treatment - Mental</u>		
388.2	<u>Health and Substance Abuse</u>	<u>129,209,000</u>	<u>129,201,000</u>
388.3	<u>Base Level Adjustment.</u> The general fund		
388.4	<u>base is \$129,197,000 in fiscal year 2022 and</u>		
388.5	<u>\$129,197,000 in fiscal year 2023.</u>		
388.6	<u>Subd. 37. Direct Care and Treatment -</u>		
388.7	<u>Community-Based Services</u>	<u>15,036,000</u>	<u>13,448,000</u>
388.8	<u>Base Level Adjustment.</u> The general fund		
388.9	<u>base is \$13,447,000 in fiscal year 2022 and</u>		
388.10	<u>\$13,447,000 in fiscal year 2023.</u>		
388.11	<u>Subd. 38. Direct Care and Treatment - Forensic</u>		
388.12	<u>Services</u>	<u>112,126,000</u>	<u>115,342,000</u>
388.13	<u>Base Level Adjustment.</u> The general fund		
388.14	<u>base is \$115,944,000 in fiscal year 2022 and</u>		
388.15	<u>\$115,944,000 in fiscal year 2023.</u>		
388.16	<u>Subd. 39. Direct Care and Treatment - Sex</u>		
388.17	<u>Offender Program</u>	<u>87,338,000</u>	<u>87,887,000</u>
388.18	<u>(a) Transfer Authority.</u> Money appropriated		
388.19	<u>for the Minnesota sex offender program may</u>		
388.20	<u>be transferred between fiscal years of the</u>		
388.21	<u>biennium with the approval of the</u>		
388.22	<u>commissioner of management and budget.</u>		
388.23	<u>(b) Base Level Adjustment.</u> The general fund		
388.24	<u>base is \$88,432,000 in fiscal year 2022 and</u>		
388.25	<u>\$88,432,000 in fiscal year 2023.</u>		
388.26	<u>Subd. 40. Direct Care and Treatment -</u>		
388.27	<u>Operations</u>	<u>47,499,000</u>	<u>47,708,000</u>
388.28	<u>(a) Community Competency Restoration</u>		
388.29	<u>Task Force.</u> \$200,000 in fiscal year 2020 is		
388.30	<u>for the Community Competency Restoration</u>		
388.31	<u>Task Force under article 3, section 38. This is</u>		
388.32	<u>a onetime appropriation and is available until</u>		
388.33	<u>June 30, 2023.</u>		

389.1 (b) Base Level Adjustment. The general fund
 389.2 base is \$47,632,000 in fiscal year 2022 and
 389.3 \$47,632,000 in fiscal year 2023.

389.4 Subd. 41. Technical Activities 95,781,000 96,008,000

389.5 (a) Generally. This appropriation is from the
 389.6 federal TANF fund.

389.7 (b) Base Level Adjustment. The TANF fund
 389.8 base is \$96,360,000 in fiscal year 2022 and
 389.9 \$96,620,000 in fiscal year 2023.

389.10 Sec. 3. COMMISSIONER OF HEALTH

389.11 Subdivision 1. Total Appropriation \$ 225,900,000 \$ 227,953,000

389.12 Appropriations by Fund

	<u>2020</u>	<u>2021</u>
389.13		
389.14 <u>General</u>	<u>157,897,000</u>	<u>157,988,000</u>
389.15 <u>State Government</u>		
389.16 <u>Special Revenue</u>	<u>56,290,000</u>	<u>58,252,000</u>
389.17 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

389.18 The amounts that may be spent for each
 389.19 purpose are specified in the following
 389.20 subdivisions.

389.21 Subd. 2. Health Improvement

389.22 Appropriations by Fund

389.23 <u>General</u>	<u>129,824,000</u>	<u>129,096,000</u>
389.24 <u>State Government</u>		
389.25 <u>Special Revenue</u>	<u>7,150,000</u>	<u>6,969,000</u>
389.26 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

389.27 (a) TANF Appropriations. (1) \$3,579,000 in
 389.28 fiscal year 2020 and \$3,579,000 in fiscal year
 389.29 2021 are from the TANF fund for home
 389.30 visiting and nutritional services under
 389.31 Minnesota Statutes, section 145.882,
 389.32 subdivision 7, clauses (6) and (7). Funds must
 389.33 be distributed to community health boards

390.1 according to Minnesota Statutes, section
390.2 145A.131, subdivision 1;
390.3 (2) \$2,000,000 in fiscal year 2020 and
390.4 \$2,000,000 in fiscal year 2021 are from the
390.5 TANF fund for decreasing racial and ethnic
390.6 disparities in infant mortality rates under
390.7 Minnesota Statutes, section 145.928,
390.8 subdivision 7;
390.9 (3) \$4,978,000 in fiscal year 2020 and
390.10 \$4,978,000 in fiscal year 2021 are from the
390.11 TANF fund for the family home visiting grant
390.12 program under Minnesota Statutes, section
390.13 145A.17. \$4,000,000 of the funding in each
390.14 fiscal year must be distributed to community
390.15 health boards according to Minnesota Statutes,
390.16 section 145A.131, subdivision 1. \$978,000 of
390.17 the funding in each fiscal year must be
390.18 distributed to tribal governments according to
390.19 Minnesota Statutes, section 145A.14,
390.20 subdivision 2a;
390.21 (4) \$1,156,000 in fiscal year 2020 and
390.22 \$1,156,000 in fiscal year 2021 are from the
390.23 TANF fund for family planning grants under
390.24 Minnesota Statutes, section 145.925; and
390.25 (5) The commissioner may use up to 6.23
390.26 percent of the amounts appropriated from the
390.27 TANF fund each year to conduct the ongoing
390.28 evaluations required under Minnesota Statutes,
390.29 section 145A.17, subdivision 7, and training
390.30 and technical assistance as required under
390.31 Minnesota Statutes, section 145A.17,
390.32 subdivisions 4 and 5.
390.33 **(b) TANF Carryforward. Any unexpended**
390.34 **balance of the TANF appropriation in the first**

391.1 year of the biennium does not cancel but is
391.2 available for the second year.

391.3 **(c) Perinatal Hospice Grants.** \$515,000 in
391.4 fiscal year 2020 is from the general fund for
391.5 perinatal hospice development, training, and
391.6 awareness grants under article 9, section 54.
391.7 Eligible entities may apply for multiple grants.
391.8 The commissioner may use up to \$15,000 for
391.9 administration of these grants. This is a
391.10 onetime appropriation and is available until
391.11 June 30, 2023.

391.12 **(d) Statewide Tobacco Cessation.** \$1,598,000
391.13 in fiscal year 2020 and \$2,748,000 in fiscal
391.14 year 2021 are from the general fund for
391.15 statewide tobacco cessation services under
391.16 Minnesota Statutes, section 144.397. The base
391.17 for this appropriation is \$2,878,000 in fiscal
391.18 year 2022 and \$2,878,000 in fiscal year 2023.

391.19 **(e) Safe Harbor for Sexually Exploited**
391.20 **Youth.** \$500,000 in fiscal year 2020 and
391.21 \$500,000 in fiscal year 2021 are from the
391.22 general fund for the statewide program for
391.23 safe harbor for sexually exploited youth. Of
391.24 these amounts:

391.25 (1) \$470,000 in fiscal year 2020 and \$470,000
391.26 in fiscal year 2021 are for grants for
391.27 comprehensive services, including
391.28 trauma-informed, culturally specific services
391.29 for sexually exploited youth under Minnesota
391.30 Statutes, section 145.4716;

391.31 (2) \$5,000 in fiscal year 2020 and \$5,000 in
391.32 fiscal year 2021 are for evaluation activities
391.33 under Minnesota Statutes, section 145.4718.
391.34 The base appropriation includes \$45,000 in

392.1 fiscal year 2020 and \$45,000 in fiscal year
392.2 2021 for evaluation activities under Minnesota
392.3 Statutes, section 145.4718; and
392.4 (3) \$25,000 in fiscal year 2020 and \$25,000
392.5 in fiscal year 2021 are for training and
392.6 protocol implementation.

392.7 **(f) Study on Breastfeeding Disparities.**
392.8 \$79,000 in fiscal year 2020 is from the general
392.9 fund for a study on breastfeeding disparities.

392.10 **(g) Palliative Care Advisory Council.**
392.11 \$44,000 in fiscal year 2020 and \$44,000 in
392.12 fiscal year 2021 are from the general fund for
392.13 the Palliative Care Advisory Council under
392.14 Minnesota Statutes, section 144.059. This is
392.15 a onetime appropriation.

392.16 **(h) Study on the Increase in Abortions after**
392.17 **20 Weeks.** \$42,000 in fiscal year 2020 is from
392.18 the general fund for an evaluation of the
392.19 increase in abortions occurring after the
392.20 gestational age of 20 weeks and the reasons
392.21 for the increase. The commissioner shall report
392.22 the findings to the chairs and ranking minority
392.23 members of the legislative committees with
392.24 jurisdiction over health care policy and finance
392.25 by February 15, 2020. This is a onetime
392.26 appropriation.

392.27 **(i) Positive Abortion Alternatives Grants.**
392.28 \$336,000 in fiscal year 2020 and \$336,000 in
392.29 fiscal year 2021 are from the general fund for
392.30 the positive abortion alternatives grants under
392.31 Minnesota Statutes, section 145.4235.

392.32 **(j) Mental Health Services for Pre- and**
392.33 **Postpartum Women.** \$100,000 in fiscal year
392.34 2020 is from the general fund for mental

393.1 health services to women suffering from pre-
393.2 and postpartum mood and anxiety disorders
393.3 under Minnesota Statutes, section 145.908.

393.4 This is a onetime appropriation and is
393.5 available until June 30, 2023.

393.6 **(k) Comprehensive Suicide Prevention.**

393.7 \$1,321,000 in fiscal year 2020 and \$1,321,000
393.8 in fiscal year 2021 are from the general fund
393.9 for a Minnesota-based suicide prevention
393.10 lifeline as part of the suicide prevention plan
393.11 described in Minnesota Statutes, section
393.12 145.56. This is a onetime appropriation and
393.13 is available until June 30, 2023.

393.14 **(l) Health Professionals Loan Forgiveness.**

393.15 \$354,000 in fiscal year 2020 is from the
393.16 general fund for transfer to the health
393.17 professional education loan forgiveness
393.18 program account for loan forgiveness for
393.19 mental health professionals agreeing to
393.20 practice in designated rural areas under
393.21 Minnesota Statutes, section 144.1501,
393.22 subdivision 2, paragraph (a), clause (1). This
393.23 is a onetime appropriation and is available
393.24 until June 30, 2023. If the commissioner does
393.25 not receive enough qualified applicants to use
393.26 the entire allocation of funds as required, the
393.27 remaining funds may be used for loan
393.28 forgiveness for mental health professionals
393.29 agreeing to practice in underserved urban
393.30 communities or may be allocated
393.31 proportionally among other eligible
393.32 professionals agreeing to practice in
393.33 designated rural areas.

393.34 **(m) Cannabinoid Products Workgroup.**

393.35 \$10,000 in fiscal year 2020 is from the general

394.1 fund for the cannabinoid products workgroup
 394.2 under article 1, section 56. This is a onetime
 394.3 appropriation.

394.4 (n) Base Level Adjustment. The general fund
 394.5 base is \$128,431,000 in fiscal year 2022 and
 394.6 \$127,831,000 in fiscal year 2023.

394.7 Subd. 3. Health Protection

394.8 Appropriations by Fund

394.9	<u>General</u>	<u>18,637,000</u>	<u>19,456,000</u>
394.10	<u>State Government</u>		
394.11	<u>Special Revenue</u>	<u>49,140,000</u>	<u>51,283,000</u>

394.12 (a) Public Health Laboratory Equipment.
 394.13 \$840,000 in fiscal year 2020 and \$655,000 in
 394.14 fiscal year 2021 are from the general fund for
 394.15 equipment for the public health laboratory.
 394.16 This is a onetime appropriation and is
 394.17 available until June 30, 2023.

394.18 (b) Base Level Adjustment. The general fund
 394.19 base is \$18,801,000 in fiscal year 2022 and
 394.20 \$18,801,000 in fiscal year 2023. The state
 394.21 government special revenue fund base is
 394.22 \$51,283,000 in fiscal year 2022 and
 394.23 \$51,290,000 in fiscal year 2023.

394.24	<u>Subd. 4. Health Operations</u>	<u>9,436,000</u>	<u>9,436,000</u>
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394.25 Sec. 4. HEALTH-RELATED BOARDS

394.26	<u>Subdivision 1. Total Appropriation</u>	<u>\$ 23,996,000</u>	<u>\$ 24,016,000</u>
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394.27 This appropriation is from the state
 394.28 government special revenue fund unless
 394.29 specified otherwise. The amounts that may be
 394.30 spent for each purpose are specified in the
 394.31 following subdivisions.

394.32	<u>Subd. 2. Board of Chiropractic Examiners</u>	<u>605,000</u>	<u>605,000</u>
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394.33	<u>Subd. 3. Board of Dentistry</u>	<u>1,468,000</u>	<u>1,465,000</u>
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395.1 **Emeritus Licensing Activities.** \$8,000 in
 395.2 fiscal year 2020 and \$5,000 in fiscal year 2021
 395.3 are for emeritus licensing activities under
 395.4 Minnesota Statutes, section 150A.06.

395.5 <u>Subd. 4. Board of Dietetics and Nutrition</u>		
395.6 <u>Practice</u>	<u>145,000</u>	<u>145,000</u>
395.7 <u>Subd. 5. Board of Marriage and Family Therapy</u>	<u>376,000</u>	<u>377,000</u>
395.8 <u>Subd. 6. Board of Medical Practice</u>	<u>5,405,000</u>	<u>5,405,000</u>

395.9 **Health Professional Services Program.** This
 395.10 appropriation includes \$1,023,000 in fiscal
 395.11 year 2020 and \$1,002,000 in fiscal year 2021
 395.12 for the health professional services program.

395.13 <u>Subd. 7. Board of Nursing</u>	<u>4,916,000</u>	<u>4,916,000</u>
395.14 <u>Subd. 8. Board of Nursing Home Administrators</u>	<u>2,898,000</u>	<u>2,898,000</u>

395.15 (a) **Administrative Services Unit - Volunteer**
 395.16 **Health Care Provider Program.** Of this
 395.17 appropriation, \$150,000 in fiscal year 2020
 395.18 and \$150,000 in fiscal year 2021 are to pay
 395.19 for medical professional liability coverage
 395.20 required under Minnesota Statutes, section
 395.21 214.40.

395.22 (b) **Administrative Services Unit -**
 395.23 **Retirement Costs.** Of this appropriation,
 395.24 \$558,000 in fiscal year 2020 is for the
 395.25 administrative services unit to pay for the
 395.26 retirement costs of health-related board
 395.27 employees. This funding may be transferred
 395.28 to the health board incurring retirement costs.
 395.29 Any board that has an unexpended balance for
 395.30 an amount transferred under this paragraph
 395.31 shall transfer the unexpended amount to the
 395.32 administrative services unit. These funds are
 395.33 available either year of the biennium.

396.1 **(c) Administrative Services Unit - Contested**
 396.2 **Cases and Other Legal Proceedings.** Of this
 396.3 appropriation, \$200,000 in fiscal year 2020
 396.4 and \$200,000 in fiscal year 2021 are for costs
 396.5 of contested case hearings and other
 396.6 unanticipated costs of legal proceedings
 396.7 involving health-related boards. Upon
 396.8 certification by a health-related board to the
 396.9 administrative services unit that costs will be
 396.10 incurred and that there is insufficient money
 396.11 available to pay for the costs out of
 396.12 appropriations currently available to that
 396.13 board, the administrative services unit is
 396.14 authorized to transfer money from this
 396.15 appropriation to the board for payment of
 396.16 those costs with the approval of the
 396.17 commissioner of management and budget. The
 396.18 commissioner of management and budget must
 396.19 require any board that has an unexpended
 396.20 balance for an amount transferred under this
 396.21 paragraph to transfer the unexpended amount
 396.22 to the administrative services unit to be
 396.23 deposited in the state government special
 396.24 revenue fund.

396.25	<u>Subd. 9. Board of Optometry</u>	<u>176,000</u>	<u>176,000</u>
396.26	<u>Subd. 10. Board of Pharmacy</u>	<u>3,326,000</u>	<u>3,338,000</u>
396.27	<u>\$25,000 in fiscal year 2020 is for random</u>		
396.28	<u>audits under Minnesota Statutes, section</u>		
396.29	<u>152.126, subdivision 6, paragraph (k), of</u>		
396.30	<u>permissible users of the prescription</u>		
396.31	<u>monitoring program. This is a onetime</u>		
396.32	<u>appropriation.</u>		
396.33	<u>Subd. 11. Board of Physical Therapy</u>	<u>557,000</u>	<u>559,000</u>
396.34	<u>Subd. 12. Board of Podiatric Medicine</u>	<u>209,000</u>	<u>209,000</u>

397.1	<u>Subd. 13. Board of Psychology</u>		<u>1,285,000</u>	<u>1,285,000</u>
397.2	<u>Subd. 14. Board of Social Work</u>		<u>1,289,000</u>	<u>1,291,000</u>
397.3	<u>Subd. 15. Board of Veterinary Medicine</u>		<u>332,000</u>	<u>338,000</u>
397.4	<u>Subd. 16. Board of Behavioral Health and</u>			
397.5	<u>Therapy</u>		<u>669,000</u>	<u>669,000</u>
397.6	<u>Subd. 17. Board of Occupational Therapy</u>			
397.7	<u>Practice</u>		<u>340,000</u>	<u>340,000</u>
397.8	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>			
397.9	<u>REGULATORY BOARD</u>	<u>\$</u>	<u>3,747,000</u>	<u>\$ 3,809,000</u>
397.10	<u>(a) Cooper/Sams Volunteer Ambulance</u>			
397.11	<u>Program. \$950,000 in fiscal year 2020 and</u>			
397.12	<u>\$950,000 in fiscal year 2021 are for the</u>			
397.13	<u>Cooper/Sams volunteer ambulance program</u>			
397.14	<u>under Minnesota Statutes, section 144E.40.</u>			
397.15	<u>(1) Of this amount, \$861,000 in fiscal year</u>			
397.16	<u>2020 and \$861,000 in fiscal year 2021 are for</u>			
397.17	<u>the ambulance service personnel longevity</u>			
397.18	<u>award and incentive program under Minnesota</u>			
397.19	<u>Statutes, section 144E.40.</u>			
397.20	<u>(2) Of this amount, \$89,000 in fiscal year 2020</u>			
397.21	<u>and \$89,000 in fiscal year 2021 are for the</u>			
397.22	<u>operations of the ambulance service personnel</u>			
397.23	<u>longevity award and incentive program under</u>			
397.24	<u>Minnesota Statutes, section 144E.40.</u>			
397.25	<u>(b) EMSRB Operations. \$1,851,000 in fiscal</u>			
397.26	<u>year 2020 and \$1,913,000 in fiscal year 2021</u>			
397.27	<u>are for board operations. The base for this</u>			
397.28	<u>program is \$1,880,000 in fiscal year 2022 and</u>			
397.29	<u>\$1,880,000 in fiscal year 2023.</u>			
397.30	<u>(c) Regional Grants. \$585,000 in fiscal year</u>			
397.31	<u>2020 and \$585,000 in fiscal year 2021 are for</u>			
397.32	<u>regional emergency medical services</u>			
397.33	<u>programs, to be distributed equally to the eight</u>			

398.1 emergency medical service regions under

398.2 Minnesota Statutes, section 144E.52.

398.3 **(d) Ambulance Training Grant. \$585,000**

398.4 in fiscal year 2020 and \$585,000 in fiscal year

398.5 2021 are for training grants under Minnesota

398.6 Statutes, section 144E.35.

398.7 **(e) Base Level Adjustment.** The base is

398.8 \$3,776,000 in fiscal year 2022 and \$3,776,000

398.9 in fiscal year 2023.

398.10 Sec. 6. **COUNCIL ON DISABILITY** \$ 1,014,000 \$ 1,006,000

398.11 Sec. 7. **OMBUDSMAN FOR MENTAL**

398.12 **HEALTH AND DEVELOPMENTAL**

398.13 **DISABILITIES** \$ 2,688,000 \$ 2,438,000

398.14 **Department of Psychiatry Monitoring.**

398.15 \$100,000 in fiscal year 2020 and \$100,000 in

398.16 fiscal year 2021 are for monitoring the

398.17 Department of Psychiatry at the University of

398.18 Minnesota.

398.19 Sec. 8. **OMBUDSPERSONS FOR FAMILIES** \$ 467,000 \$ 467,000

398.20 Sec. 9. **COMMISSIONER OF MANAGEMENT**

398.21 **AND BUDGET** \$ 498,000 \$ 498,000

398.22 **(a) Transfer.** By June 30, 2019, the

398.23 commissioner shall transfer \$399,000,000

398.24 from the general fund to the health care access

398.25 fund. This is a onetime transfer.

398.26 **(b) Transfer.** By June 30, 2020, the

398.27 commissioner shall transfer \$168,776,000

398.28 from the general fund to the health care access

398.29 fund. This is a onetime transfer.

398.30 **(c) Transfer.** By June 30, 2022, the

398.31 commissioner shall transfer \$116,049,000

398.32 from the general fund to the health care access

398.33 fund. This is a onetime transfer. This

398.34 paragraph expires July 1, 2022.

399.1 **(d) Proven-Effective Practices Evaluation**399.2 **Activities.** \$498,000 in fiscal year 2020 and399.3 \$498,000 in fiscal year 2021 are from the399.4 general fund for evaluation activities under399.5 Minnesota Statutes, section 16A.055,399.6 subdivision 1a.399.7 Sec. 10. **COMMISSIONER OF COMMERCE** \$ **39,000** \$ **-0-**

399.8 Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 7, is amended to

399.9 read:

399.10 Sec. 7. **OMBUDSMAN FOR MENTAL**399.11 **HEALTH AND DEVELOPMENTAL**399.12 **DISABILITIES**\$ **2,407,000** \$**2,427,000****2,177,000**399.13 **Department of Psychiatry Monitoring.**

399.14 \$100,000 in fiscal year 2018 and \$100,000 in

399.15 fiscal year 2019 are for monitoring the

399.16 Department of Psychiatry at the University of

399.17 Minnesota.

399.18 Sec. 12. **TRANSFERS.**399.19 **Subdivision 1. Forecasted programs.** The commissioner of human services, with the399.20 approval of the commissioner of management and budget, may transfer unencumbered399.21 appropriation balances for the biennium ending June 30, 2021, within fiscal years among399.22 the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance399.23 under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, housing399.24 support, the entitlement portion of Northstar Care for Children under Minnesota Statutes,399.25 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment399.26 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs399.27 and ranking minority members of the senate Health and Human Services Finance Committee399.28 and the house of representatives Health and Human Services Finance Committee quarterly399.29 about transfers made under this subdivision.399.30 **Subd. 2. Administration.** Positions, salary money, and nonsalary administrative money399.31 may be transferred within the Departments of Health and Human Services only to set up399.32 and manage operating budgets with the advance approval of the commissioner of management399.33 and budget. The commissioner shall inform the chairs and ranking minority members of399.34 the senate Health and Human Services Finance Committee and the house of representatives

400.1 Health and Human Services Finance Committee quarterly about the transfers made under
400.2 this subdivision.

400.3 Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

400.4 The commissioners of health and human services shall not use indirect cost allocations
400.5 to pay for the operational costs of any program for which they are responsible.

400.6 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

400.7 All uncodified language contained in this article expires on June 30, 2021, unless a
400.8 different expiration date is explicit.

400.9 Sec. 15. **EFFECTIVE DATE.**

400.10 This article is effective July 1, 2019, unless a different effective date is specified.

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.

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.

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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.

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, diversionsary 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.

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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.

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

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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 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;

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- (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).

(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.

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

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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 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;
- (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;

(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;

(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.

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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 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

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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.

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.

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(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.

(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

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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.

(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:

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- (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

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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

(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%

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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%
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 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.

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(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.

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.

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(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 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

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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 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

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(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 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,

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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 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

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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.

144.1464 SUMMER HEALTH CARE INTERNS.

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants, within available appropriations, to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and postsecondary summer health care intern program. The purpose of the program is to expose interested secondary and postsecondary pupils to various careers within the health care profession.

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals, clinics, nursing facilities, and home care providers that agree to:

(1) provide secondary and postsecondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and postsecondary summer health care interns;

(3) pay one-half the costs of employing the secondary and postsecondary summer health care intern;

(4) interview and hire secondary and postsecondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each postsecondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital, clinic, nursing facility, or home care provider, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

(2) be from a school district in proximity to the facility.

(c) In order to be eligible to be hired as a postsecondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility.

(d) Hospitals, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and postsecondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

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Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be postsecondary students, unless the program does not receive enough qualified secondary applicants per fiscal year. No more than five pupils may be selected from any secondary or postsecondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. **Contract.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and postsecondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. **Program administration.** In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

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(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. Career guidance and support services. (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. Clinical preparation. (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. International medical graduate primary care residency grant program and revolving account. (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed \$150,000 per residency position per year.

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Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay \$15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. Voluntary hospital programs. A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. Board of Medical Practice. Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. Consultation with stakeholders. The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

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- (ii) a health plan company;
- (iii) the Minnesota Medical Association;
- (iv) licensed physicians experienced in working with international medical graduates; and
- (v) the Minnesota Academy of Physician Assistants;
- (3) community-based organizations:
 - (i) organizations serving immigrant and refugee communities of Minnesota;
 - (ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and
 - (iii) the Minnesota Association of Community Health Centers;
- (4) higher education:
 - (i) University of Minnesota;
 - (ii) Mayo Clinic School of Health Professions;
 - (iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and
 - (iv) Minnesota physician assistant education programs; and
- (5) two international medical graduates.

Subd. 10. **Report.** The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

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.0625 COVERED SERVICES.

Subd. 31c. **Preferred incontinence product program.** The commissioner shall implement a preferred incontinence product program by July 1, 2018. The program shall require the commissioner to volume purchase incontinence products and related supplies in accordance with section 256B.04, subdivision 14. Medical assistance coverage for incontinence products and related supplies shall conform to the limitations established under the program.

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

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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.

256L.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 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

(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

(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.

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.