SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 2452

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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		Comm report: To pass as amended Second reading

A bill for an act

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

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

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

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

ARTICLE 1

PROGRAM INTEGRITY

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

15C.02 LIABILITY FOR CERTAIN ACTS.

(a) A person who commits any act described in clauses (1) to (7) is liable to the state or the political subdivision for a civil penalty ~~of not less than $5,500 and not more than $11,000~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 authorized by the Internal Revenue Service.

(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 includes all deposits into accounts owned or controlled by the applicant, including amounts spent on personal expenses including rent, mortgage, automobile-related expenses, utilities, and food and amounts received as salary or draws from business accounts. Income does not include a deposit specifically identified by the applicant as a loan or gift, for which the applicant provides the source, date, amount, and repayment terms. Income and assets must be verified with documentary evidence. If the applicant does not have sufficient evidence of income or assets, verification must be obtained from the source of the income or assets.

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

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~~ zero months from the date of application for child care assistance.

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

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

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

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

Subd. 9a. **Child care ~~centers~~ authorizations; ~~assistance~~ dependents of employees and controlling individuals.** (a) A licensed or license-exempt child care center ~~may~~ must not receive authorizations for ~~25 or fewer children~~ more than seven children who are dependents of the center's employees or controlling individuals. ~~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)~~ (b) 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.

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

Subd. 6. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must keep accurate and legible 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.

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

(c) A county or the commissioner may deny or revoke a provider's authorization ~~as a child care provider to any applicant, rescind authorization of any provider,~~ to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment ~~claim in the system~~ under paragraph (d) 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.~~

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

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

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

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

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

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

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

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

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

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

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

(2) the date of the suspension;

(3) the length of the suspension;

(4) the requirements and procedures for reinstatement;

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

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

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

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

Subd. 6. **Provider payments.** (a) A provider shall bill only for services documented according to section 119B.125, subdivision 6. 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~~.~~; or

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

(e) For purposes of paragraph (d), clauses (3), (5), ~~and~~ (6), and (7), 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.

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

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

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~~ calendar year, or for more than ten consecutive full-day absent days. "Absent day" means any day that the child is authorized and scheduled to be in care with a licensed provider or license exempt center and the child is absent from the care for the entire day. 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~~ calendar 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~~ calendar year; and ten consecutive full-day absent days.

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

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

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

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

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

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

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) consumer directed community supports; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

(k) The commissioner shall:

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

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

(3) investigate all complaints and appeals.

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

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

(1) $0.22 per mile for client reimbursement;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) subdivision 18; and

(3) subdivision 18a.

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

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

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

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

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

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

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

(2) printed name of the recipient;

(3) date the entry is made;

(4) date the service is provided;

(5) origination site and destination site;

(6) who provided the service;

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

(8) the medically necessary mental health service delivered.

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

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

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

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

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

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

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

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

(i) fraud hotline complaints;

(ii) claims data mining; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) other information required by the commissioner.

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

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

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

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

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

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

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

(1) sanctions under subdivision 2;

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

(3) other fines or penalties allowed by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) sterile procedures;

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

(3) home maintenance or chore services;

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

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

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

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

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

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

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

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

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency ~~and~~, meet the definition of qualified professional under section 256B.0625, subdivision 19c, and enroll with the department as a qualified professional after clearing a background study. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) agency administrative activities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) any other manner proscribed by the commissioner.

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

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

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

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

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

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

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

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) number of direct-care staff;

(2) wages of direct-care staff;

(3) hours worked by direct-care staff;

(4) overtime wages of direct-care staff;

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

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

(7) direct-care staff retention rates;

(8) direct-care staff job vacancies;

(9) amount of travel time paid;

(10) program vacancy rates; and

(11) other related data requested by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the date the documentation occurred;

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

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

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

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

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

(1) the date the documentation occurred;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

256B.5014 ~~FINANCIAL~~ REPORTING REQUIREMENTS.

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

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

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

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

(4) total annual resident days.

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

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

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

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

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

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

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

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

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

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

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

(9) have an office located in Minnesota.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

256D.0515 ASSET LIMITATIONS FOR FOOD STAMP HOUSEHOLDS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(10) the portion of an insurance settlement that is used to pay medical, funeral, and burial expenses, or to repair or replace insured property;

(11) reimbursements for medical expenses that cannot be paid by medical assistance;

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

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

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

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

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

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

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

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

(20) Minnesota supplemental aid, including retroactive payments;

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

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

(23) state-funded family subsidy program payments made under section 252.32 to help families care for children with developmental disabilities, consumer support grant funds

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

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

(25) rent rebates;

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

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

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

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

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

(31) reverse mortgages;

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

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

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

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

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

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

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

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

(40) security and utility deposit refunds;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) identity of adults;

(2) age, if necessary to determine eligibility;

(3) immigration status;

(4) income;

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

(6) vehicles;

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

(8) inconsistent information, if related to eligibility;

(9) residence;

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

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

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

(13) direct or indirect gifts of money.

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

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

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

(1) earned income:

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

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

(2) unearned income, which includes:

(i) interest and dividends from investments and savings;

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

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

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

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

(vi) cash prizes and winnings;

(vii) unemployment insurance income;

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

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

(x) retirement benefits;

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

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

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

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

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

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

(xvii) spousal support.

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

Sec. 49. **ELECTRONIC ~~SERVICE DELIVERY DOCUMENTATION SYSTEM~~ VISIT VERIFICATION.**

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

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

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

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 69. **REPEALER.**

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

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

ARTICLE 2
CHILDREN AND FAMILIES SERVICES

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

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

(1) according to section 13.05;

(2) according to court order;

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

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

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

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

(6) to administer federal funds or programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the participant:

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

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

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

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

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

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

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

(i) the member:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 28. **Child care assistance program.** (a) 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 are classified under section 119B.02, subdivision 6, paragraph (a). Child care assistance program payment data is classified under section 119B.02, subdivision 6, paragraph (b).

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

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

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

Subd. 6. **Data.** (a) 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.

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

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

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

(2) when the commissioner or county agency either:

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

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

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

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

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

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

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

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

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

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) an inspection of the physical plant;

(2) an inspection of records and documents;

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

(4) observation of the program in operation; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the specific law or rule violated;

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

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

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

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

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

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

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

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

245A.065 CHILD CARE FIX-IT TICKET.

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

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

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

(3) the license holder did not receive a fix-it ticket or correction order for the violation at the license holder's last licensing inspection; and

(4) the violation ~~can~~ cannot be corrected at the time of inspection ~~or within 48 hours, excluding Saturdays, Sundays, and holidays; and~~

~~(5) the license holder corrects the violation at the time of inspection or agrees to correct the violation within 48 hours, excluding Saturdays, Sundays, and holidays~~.

(b) The commissioner shall not issue a fix-it ticket for violations that are corrected at the time of the inspection.

(c) The fix-it ticket must state:

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

(2) the specific law or rule violated; and

(3) that the violation ~~was corrected at the time of inspection or~~ must be corrected within 48 hours, excluding Saturdays, Sundays, and holidays.

~~(c)~~ (d) The commissioner shall not publicly publish a fix-it ticket on the department's website, unless required by federal law.

~~(d)~~ (e) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it ticket, the license holder must correct the violation and within one week submit evidence to the licensing agency that the violation was corrected.

~~(e)~~ (f) If the violation is not corrected ~~at the time of inspection or~~ within 48 hours, excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that the license holder corrected the violation, the commissioner ~~must~~ may issue a correction order, according to section 245A.06, for the violation of Minnesota law or rule identified in the fix-it ticket ~~according to section 245A.06~~.

~~(f) The commissioner shall, following consultation with family child care license holders, child care center license holders, and county agencies, issue a report by October 1, 2017, that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503, that are eligible for a fix-it ticket. The commissioner shall provide the report to county agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over child care, and shall post the report to the department's website~~(g) Beginning July 1, 2020, the commissioner may issue a fix-it ticket to a family child care license holder if, upon inspection, the commissioner finds a Level 3 violation as provided in section 245A.055, subdivision 3.

Subd. 2. **Fix-it ticket laws and rules.** (a) For family child care license holders, violations of the following laws and rules may qualify only for a fix-it ticket: 9502.0335, subpart 10; 9502.0375, subpart 2; 9502.0395; 9502.0405, subpart 3; 9502.0405, subpart 4, item A; 9502.0415, subpart 3; 9502.0425, subpart 2 (outdoor play spaces must be free from litter, rubbish, unlocked vehicles, or human or animal waste); 9502.0425, subpart 3 (wading pools must be kept clean); 9502.0425, subpart 5; 9502.0425, subpart 7, item F (screens on exterior doors and windows when biting insects are prevalent); 9502.0425, subpart 8; 9502.0425, subpart 10; 9502.0425, subpart 11 (decks free of splinters); 9502.0425, subpart 13 (toilets flush thoroughly); 9502.0425, subpart 16; 9502.0435, subpart 1; 9502.0435, subpart 3; 9502.0435, subpart 7; 9502.0435, subpart 8, item B; 9502.0435, subpart 8, item E; 9502.0435, subpart 12, items A through E; 9502.0435, subpart 13; 9502.0435, subpart 14; 9502.0435, subpart 15; 9502.0435, subpart 15, items A and B; 9502.0445, subpart 1, item B; 9502.0445,

subpart 3, items B through D; 9502.0445, subpart 4, items A through C; 245A.04, subdivision 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.146, subdivision 3, paragraph (c); 245A.148; 245A.152; 245A.50, subdivision 7; 245A.51, subdivision 3, paragraph (d) (emergency preparedness plan available for review and posted in prominent location).

(b) For child care center license holders, violations of the following laws and rules may qualify only for a fix-it ticket: 9503.0120, item B; 9503.0120, item E; 9503.0125, item E; 9503.0125, item F; 9503.0125, item I; 9503.0125, item M; 9503.0140, subpart 2; 9503.0140, subpart 7, item D; 9503.0140, subpart 9; 9503.0140, subpart 10; 9503.0140, subpart 13; 9503.0140, subpart 14; 9503.0140, subpart 15; 9503.0140, subpart 16 (item missing from first-aid kit); 9503.0140, subpart 18; 9503.0140, subpart 19; 9503.0140, subpart 20; 9503.0140, subpart 21 (emergency plan not posted in prominent place); 9503.0145, subpart 2; 9503.0145, subpart 3; 9503.0145, subpart 4, item D; 9503.0145, subpart 8 (drinking water provided in single service cups or at an accessible drinking fountain); 9503.0155, subpart 7, item D; 9503.0155, subpart 13; 9503.0155, subpart 16; 9503.0155, subpart 17; 9503.0155, subpart 18, item D; 9503.0170, subpart 3; 9503.0145, subpart 7, item D; 245A.04, subdivision 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.14, subdivision 8, paragraph (b) (experienced aide identification posting); 245A.146, subdivision 3, paragraph (c); 245A.152; 245A.41, subdivision 3, paragraph (d); 245A.41, subdivision 3, paragraph (e); 245A.41, subdivision 3, paragraph (f).

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

Sec. 12. **[245A.066] CHILD CARE TECHNICAL ASSISTANCE.**

Subdivision 1. **Verbal technical assistance.** The commissioner may provide verbal technical assistance to a family child care license holder if, upon inspection, the commissioner finds a Level 1 violation as provided in section 245A.055, subdivision 3.

Subd. 2. **Technical assistance notice.** (a) The commissioner may issue a written technical assistance notice to a family child care license holder if, upon inspection, the commissioner finds a Level 2 violation as provided in section 245A.055, subdivision 3.

(b) The technical assistance notice must state:

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

(2) the specific law or rule violated; and

(3) examples of how to correct the violation.

(c) The commissioner shall not publicly publish a written technical assistance notice on the department's website, unless required by federal law.

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

Sec. 13. Minnesota Statutes 2018, section 245A.14, subdivision 4, is amended to read:

Subd. 4. **Special family day care homes.** Nonresidential child care programs serving 14 or fewer children that are conducted at a location other than the license holder's own residence shall be licensed under this section and the rules governing family day care or group family day care if:

(a) The license holder is the primary provider of care and the nonresidential child care program is conducted in a dwelling that is located on a residential lot;

(b) The license holder is an employer who may or may not be the primary provider of care, and the purpose for the child care program is to provide child care services to children of the license holder's employees;

(c) The license holder is a church or religious organization;

(d) The license holder is a community collaborative child care provider. For purposes of this subdivision, a community collaborative child care provider is a provider participating in a cooperative agreement with a community action agency as defined in section 256E.31;

(e) The license holder is a not-for-profit agency that provides child care in a dwelling located on a residential lot and the license holder maintains two or more contracts with community employers or other community organizations to provide child care services. The county licensing agency may grant a capacity variance to a license holder licensed under this paragraph to exceed the licensed capacity of 14 children by no more than five children during transition periods related to the work schedules of parents, if the license holder meets the following requirements:

(1) the program does not exceed a capacity of 14 children more than a cumulative total of four hours per day;

(2) the program meets a one to seven staff-to-child ratio during the variance period;

(3) all employees receive at least an extra four hours of training per year than required in the rules governing family child care each year;

(4) the facility has square footage required per child under Minnesota Rules, part 9502.0425;

(5) the program is in compliance with local zoning regulations;

(6) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided in the Minnesota State Fire Code 2003, Section 202; and

(7) any age and capacity limitations required by the fire code inspection and square footage determinations shall be printed on the license; ~~or~~

(f) The license holder is the primary provider of care and has located the licensed child care program in a commercial space, if the license holder meets the following requirements:

(1) the program is in compliance with local zoning regulations;

(2) the program is in compliance with the applicable fire code as follows:

(i) if the program serves more than five children older than 2-1/2 years of age, but no more than five children 2-1/2 years of age or less, the applicable fire code is educational occupancy, as provided in Group E Occupancy under the Minnesota State Fire Code 2003, Section 202; or

(ii) if the program serves more than five children 2-1/2 years of age or less, the applicable fire code is Group I-4 Occupancies, as provided under the Minnesota State Fire Code 2003, Section 202;

(3) any age and capacity limitations required by the fire code inspection and square footage determinations are printed on the license; and

(4) the license holder prominently displays the license issued by the commissioner which contains the statement "This special family child care provider is not licensed as a child care center~~.~~"; or

(g) The license holder is the primary provider of care and has located the licensed child care program in a portion of a building that is used exclusively for the purpose of providing child care services, if the license holder meets the requirements in paragraph (f), clauses (1) to (4), and if any available shared kitchen, bathroom, or other space that the provider uses is separate from the indoor activity area used by the children.

Sec. 14. Minnesota Statutes 2018, section 245A.14, is amended by adding a subdivision to read:

Subd. 16. **Water bottles in child care centers.** Notwithstanding Minnesota Rules, part 9503.0145, subpart 8, a child care center may provide drinking water for children in individual covered water bottles, labeled with the child's name. Water bottles provided by the child care center must be washed, rinsed, and sanitized daily after use and stored clean and dry in a manner that protects them from contamination.

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

Sec. 15. Minnesota Statutes 2018, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that, before the implementation of NETStudy 2.0, county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; and

(7) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing ~~review~~ inspection at least annually.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing ~~review~~ inspection completed, including the date of the ~~review~~ inspection, and any ~~licensing~~ correction order issued; and

(2) any death, serious injury, or determination of substantiated maltreatment.

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

Sec. 16. Minnesota Statutes 2018, section 245A.50, subdivision 1, is amended to read:

Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must comply with the training requirements in this section.

(b) Helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.

(c) Training requirements established under this section that must be completed prior to initial licensure must be satisfied only by a newly licensed child care provider or by a child care provider who has not held an active child care license in Minnesota in the previous 12 months. A child care provider ~~who relocates within the state or~~ who voluntarily cancels a license or allows the license to lapse for a period of less than 12 months and who seeks reinstatement of the lapsed or canceled license within 12 months of the lapse or cancellation must satisfy the annual, ongoing training requirements, and is not required to satisfy the training requirements that must be completed prior to initial licensure. A child care provider who relocates within the state must (1) satisfy the annual, ongoing training requirements according to the schedules established in this section and (2) not be required to satisfy the training requirements under this section that the child care provider completed prior to initial licensure. If a licensed provider moves to a new county, the new county is prohibited from requiring the provider to complete any orientation class or training for new providers.

Sec. 17. Minnesota Statutes 2018, section 245A.50, subdivision 2, is amended to read:

Subd. 2. **Child development and learning and behavior guidance training.** (a) For purposes of family and group family child care, the license holder and each adult caregiver who provides care in the licensed setting for more than 30 days in any 12-month period shall complete and document at least four hours of child growth and learning and behavior guidance training prior to initial licensure, and before caring for children. For purposes of this subdivision, "child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community. "Behavior guidance training" means training in the understanding of the functions of child behavior and strategies for managing challenging situations. ~~At least two hours of child development and learning or behavior guidance training must be repeated annually.~~ The training curriculum shall be developed or approved by the commissioner of human services.

(b) Notwithstanding paragraph (a), individuals are exempt from this requirement if they:

(1) have taken a three-credit course on early childhood development within the past five years;

(2) have received a baccalaureate or master's degree in early childhood education or school-age child care within the past five years;

(3) are licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) have received a baccalaureate degree with a Montessori certificate within the past five years.

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

Sec. 18. Minnesota Statutes 2018, section 245A.50, subdivision 3, is amended to read:

Subd. 3. **First aid.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person must be present in the home who has been trained in first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. First aid training must be repeated ~~every two years~~ before the license holder's license expires in the second year after the prior first aid training.

(b) A family child care provider is exempt from the first aid training requirements under this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.

Sec. 19. Minnesota Statutes 2018, section 245A.50, subdivision 4, is amended to read:

Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one caregiver must be present in the home who has been trained in cardiopulmonary resuscitation (CPR), including CPR techniques for infants and children, and in the treatment of obstructed airways. The CPR training must have been provided by an individual approved to provide CPR instruction, must be repeated at least once ~~every two years~~ before the license holder's

license expires in the second year after the prior CPR training, and must be documented in the caregiver's records.

(b) A family child care provider is exempt from the CPR training requirement in this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

(c) Persons providing CPR training must use CPR training that has been developed:

(1) by the American Heart Association or the American Red Cross and incorporates psychomotor skills to support the instruction; or

(2) using nationally recognized, evidence-based guidelines for CPR training and incorporates psychomotor skills to support the instruction.

Sec. 20. Minnesota Statutes 2018, section 245A.50, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must, at a minimum, address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Abusive head trauma training required under this subdivision must, at a minimum, address the risk factors related to shaking infants and young children, means of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(d) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development. Sudden unexpected infant death

reduction training and abusive head trauma training may be provided in a single course of no more than two hours in length.

(e) Sudden unexpected infant death reduction training and abusive head trauma training required under this subdivision must be completed in person or as allowed under subdivision 10, clause (1) or (2), at least once ~~every two years~~ before the license holder's license expires in the second year after the prior sudden unexpected infant death reduction training and abusive head trauma training. On the years when the license holder is not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the license holder must receive sudden unexpected infant death reduction training and abusive head trauma training through a video of no more than one hour in length. The video must be developed or approved by the commissioner.

(f) An individual who is related to the license holder as defined in section 245A.02, subdivision 13, and who is involved only in the care of the license holder's own infant or child under school age and who is not designated to be a caregiver, helper, or substitute, as defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the sudden unexpected infant death and abusive head trauma training.

Sec. 21. Minnesota Statutes 2018, section 245A.50, subdivision 6, is amended to read:

Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Human Services that serve a child or children under ~~nine~~ eight years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, staff person, caregiver, or helper transports a child or children under age ~~nine~~ eight in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once ~~every five years~~ before the license holder's license expires in the fifth year after the prior child passenger restraint system training. At a minimum, the training must address the proper use of child restraint systems based on the

child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

Sec. 22. Minnesota Statutes 2018, section 245A.50, subdivision 7, is amended to read:

Subd. 7. **Training requirements for family and group family child care.** For purposes of family and group family child care, the license holder and each primary caregiver must complete ~~16~~ ten hours of ongoing training each year. For purposes of this subdivision, a primary caregiver is an adult caregiver who provides services in the licensed setting for more than 30 days in any 12-month period. Repeat of topical training requirements in subdivisions 2 to 8, and the annual refresher training course in subdivision 12, shall count toward the annual ~~16-hour~~ ten-hour training requirement. Additional ongoing training subjects to meet the annual ~~16-hour~~ ten-hour training requirement must be selected from the following areas:

(1) child development and learning training under subdivision 2, paragraph (a);

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

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

Sec. 23. Minnesota Statutes 2018, section 245A.50, subdivision 9, is amended to read:

Subd. 9. **Supervising for safety; training requirement.** (a) Before initial licensure and before caring for a child, all family child care license holders and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document the completion of the six-hour Supervising for Safety for Family Child Care course developed by the commissioner.

(b) The family child care license holder and each adult caregiver who provides care in the licensed family child care home for more than 30 days in any 12-month period shall complete and document~~:~~ the completion of the two-hour courses Health and Safety I and Health and Safety II at least once before the license holder's license expires in the fifth year after the prior supervising for safety training.

~~(1) the annual completion of a two-hour active supervision course developed by the commissioner; and~~

~~(2) the completion at least once every five years of the two-hour courses Health and Safety I and Health and Safety II. A license holder's or adult caregiver's completion of either training in a given year meets the annual active supervision training requirement in clause (1).~~

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

Sec. 24. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision to read:

Subd. 12. **Annual refresher training course.** Beginning January 1, 2020, license holders, staff persons, caregivers, substitutes, and helpers must complete an annual refresher training course, as developed by the commissioner of human services. The annual refresher training course must incorporate training on: (1) active supervision; (2) child development and learning, and behavior guidance; and (3) any training required by the child care development block grant. The annual refresher training course shall not exceed two hours. Providers may

complete the annual refresher training course online through self-study. Providers must document completion of the annual refresher training course.

Sec. 25. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision to read:

Subd. 13. **Related individual training exemption.** An individual who is related to a child in a child care program may care for or have contact with that child at the child care site without completing the training requirements under this chapter, unless the individual is designated to be a caregiver, helper, or substitute in the child care program.

Sec. 26. Minnesota Statutes 2018, section 245A.50, is amended by adding a subdivision to read:

Subd. 14. **Emergency substitute caregiver training exemption.** During an emergency, substitute caregivers are exempt from training requirements under this section.

Sec. 27. Minnesota Statutes 2018, section 245A.51, subdivision 3, is amended to read:

Subd. 3. **Emergency preparedness plan.** (a) No later than September 30, 2017, a licensed family child care provider must have a written emergency preparedness plan for emergencies that require evacuation, sheltering, or other protection of children, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to children. The plan must be written on a form developed by the commissioner and updated at least annually. The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitate easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis; and

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.

(b) The license holder must train caregivers before the caregiver provides care and at least annually on the emergency preparedness plan and document completion of this training.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9502.0435, subpart 8. The date and time of the drills must be documented.

(d) The license holder must have the emergency preparedness plan available for review and posted in a prominent location. ~~The license holder must provide a physical or electronic copy of the plan to the child's parent or legal guardian upon enrollment.~~

Sec. 28. **[245A.60] OMBUDSPERSON FOR CHILD CARE PROVIDERS.**

Subdivision 1. **Appointment.** The governor shall appoint an ombudsperson in the classified service to assist child care providers, including family child care providers and legal nonlicensed child care providers, with licensing, compliance, and other issues facing child care providers. The ombudsperson must be selected without regard to the person's political affiliation. The ombudsperson shall serve a term of two years and may be removed prior to the end of the term for just cause.

Subd. 2. **Duties.** (a) The ombudsperson's duties shall include:

(1) addressing all areas of concern to child care providers related to the provision of child care services, including licensing, correction orders, penalty assessments, complaint investigations, and other interactions with agency staff;

(2) assisting providers with interactions with county licensors and with appealing correction orders;

(3) providing recommendations for child care improvement or child care provider education;

(4) operating a telephone line to answer questions and provide guidance to child care providers; and

(5) assisting child care license applicants.

(b) The ombudsperson must report annually by December 31 to the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over child care on the services provided by the ombudsperson to child care providers, including the number, types, and locations of child care providers served, and the activities of the ombudsperson to carry out the duties under this section. The commissioner shall determine the form of the report and may specify additional reporting requirements.

Subd. 3. **Staff.** The ombudsperson may appoint and compensate out of available funds a deputy, confidential secretary, and other employees in the unclassified service as authorized by law. The ombudsperson and the full-time staff are members of the Minnesota State Retirement Association. The ombudsperson may delegate to members of the staff any authority or duties of the office except the duty to formally make recommendations to a child care provider or reports to the commissioner or the legislature.

Subd. 4. **Access to records.** (a) The ombudsperson or designee, excluding volunteers, has access to data of a state agency necessary for the discharge of the ombudsperson's duties, including records classified as confidential data on individuals or private data on individuals under chapter 13 or any other law. The ombudsperson's data request must relate to a specific case and is subject to section 13.03, subdivision 4. If the data concerns an individual, the ombudsperson or designee shall first obtain the individual's consent. If the individual cannot consent and has no legal guardian, then access to the data is authorized by this section.

(b) On a quarterly basis, each state agency responsible for licensing, regulating, and enforcing state and federal laws and regulations concerning child care providers must provide the ombudsperson copies of all correction orders, penalty assessments, and complaint investigation reports for all child care providers.

Subd. 5. **Independence of action.** In carrying out the duties under this section, the ombudsperson shall operate independently of the department and may provide testimony or make periodic reports to the legislature to address areas of concern and advocate for child care providers.

Subd. 6. **Civil actions.** The ombudsperson or designee is not civilly liable for any action taken under this section if the action was taken in good faith, was within the scope of the ombudsperson's authority, and did not constitute willful or reckless misconduct.

Subd. 7. **Qualifications.** The ombudsperson must be a person who has at least five years of experience providing child care. The ombudsperson must be experienced in dealing with governmental entities, interpretation of laws and regulations, investigations, record keeping, report writing, public speaking, and management. A person is not eligible to serve as the ombudsperson while holding public office and must not have been previously employed by the Department of Human Services or as a county licensor.

Subd. 8. **Office support.** The commissioner shall provide the ombudsperson with the necessary office space, supplies, equipment, and clerical support to effectively perform the duties under this section.

Subd. 9. **Posting.** (a) The commissioner shall post on the department's website the address and telephone number for the office of the ombudsperson. The commissioner shall provide all child care providers with the address and telephone number of the office. Counties must provide child care providers with the name, address, and telephone number of the office.

(b) The ombudsperson must approve all posting and notice required by the department and counties under this subdivision.

Sec. 29. Minnesota Statutes 2018, section 252.27, subdivision 2a, is amended to read:

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

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

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 1.94 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to 5.29 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

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

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human

services which begins at 5.29 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 7.05 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

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

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

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

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

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30

days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

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

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

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

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

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

(2) the insurer denied insurance;

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

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

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

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint

of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 30. **[256.4751] PARENT-TO-PARENT PEER SUPPORT GRANTS.**

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

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

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

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

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

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

(4) has staff and volunteers located statewide; and

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

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

(e) Grant recipients must report to the commissioner of human services annually by January 15 on the services and programs funded by the appropriation. The report must include measurable outcomes from the previous year, including the number of families served and the number of volunteer support parents trained.

Sec. 31. Minnesota Statutes 2018, section 256B.14, subdivision 2, is amended to read:

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third

of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules shall ~~be consistent with the requirements of section 252.27 for~~ not apply to parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the TEFRA option or for the purposes of accessing home and community-based waiver services. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

Sec. 32. Minnesota Statutes 2018, section 256M.41, subdivision 3, is amended to read:

Subd. 3. **Payments ~~based on performance.~~** ~~(a)~~ The commissioner shall make payments under this section to each county ~~board on a calendar year basis in an amount determined under paragraph (b)~~ on or before July 10 of each year.

~~(b) Calendar year allocations under subdivision 1 shall be paid to counties in the following manner:~~

~~(1) 80 percent of the allocation as determined in subdivision 1 must be paid to counties on or before July 10 of each year;~~

~~(2) ten percent of the allocation shall be withheld until the commissioner determines if the county has met the performance outcome threshold of 90 percent based on face-to-face contact with alleged child victims. In order to receive the performance allocation, the county child protection workers must have a timely face-to-face contact with at least 90 percent of all alleged child victims of screened-in maltreatment reports. The standard requires that each initial face-to-face contact occur consistent with timelines defined in section 626.556,~~

~~subdivision 10, paragraph (i). The commissioner shall make threshold determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement; and~~

~~(3) ten percent of the allocation shall be withheld until the commissioner determines that the county has met the performance outcome threshold of 90 percent based on face-to-face visits by the case manager. In order to receive the performance allocation, the total number of visits made by caseworkers on a monthly basis to children in foster care and children receiving child protection services while residing in their home must be at least 90 percent of the total number of such visits that would occur if every child were visited once per month. The commissioner shall make such determinations in January of each year and payments to counties meeting the performance outcome threshold shall occur in February of each year. Any withheld funds from this appropriation for counties that do not meet this requirement shall be reallocated by the commissioner to those counties meeting the requirement. For 2015, the commissioner shall only apply the standard for monthly foster care visits.~~

~~(c) The commissioner shall work with stakeholders and the Human Services Performance Council under section 402A.16 to develop recommendations for specific outcome measures that counties should meet in order to receive funds withheld under paragraph (b), and include in those recommendations a determination as to whether the performance measures under paragraph (b) should be modified or phased out. The commissioner shall report the recommendations to the legislative committees having jurisdiction over child protection issues by January 1, 2018.~~

Sec. 33. Minnesota Statutes 2018, section 256M.41, is amended by adding a subdivision to read:

Subd. 4. **County performance on child protection measures.** The commissioner shall set child protection measures and standards. The commissioner shall require an underperforming county to demonstrate that the county designated sufficient funds and implemented a reasonable strategy to improve child protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's funds under this section toward the performance improvement plan. Sanctions under section 256M.20, subdivision 3, related to noncompliance with federal performance standards also apply.

Sec. 34. **[260C.216] FOSTER CARE RECRUITMENT GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** The commissioner of human services shall make grants to facilitate partnerships between counties and community groups or faith communities to develop and utilize innovative, nontraditional shared recruitment methods to increase and stabilize the number of available foster care families.

Subd. 2. **Eligibility.** An eligible applicant for a foster care recruitment grant under subdivision 1 is an organization or entity that:

(1) provides a written description identifying the county and community organizations or faith communities that will partner to develop innovative shared methods to recruit families through their community or faith organizations for foster care in the county;

(2) agrees to incorporate efforts by the partnership or a third party to offer additional support services including host families, family coaches, or resource referrals for families in crisis such as homelessness, unemployment, hospitalization, substance abuse treatment, incarceration, or domestic violence, as an alternative to foster care; and

(3) describes how the proposed partnership model can be generalized to be used in other areas of the state.

Subd. 3. **Allowable grant activities.** Grant recipients may use grant funds to:

(1) develop materials that promote the partnership's innovative methods of nontraditional recruitment of foster care families through the partner community organizations or faith communities;

(2) develop an onboarding vehicle or training program for recruited foster care families that is accessible, relatable, and easy to understand, to be used by the partner community organizations or faith communities;

(3) establish sustainable communication between the partnership and the recruited families for ongoing support; or

(4) provide support services including host families, family coaches, or resource referrals for families in crisis such as homelessness, unemployment, hospitalization, substance abuse treatment, incarceration, or domestic violence, as an alternative to the foster care system.

Subd. 4. **Reporting** The commissioner shall report on the use of foster care recruitment grants to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by December 31, 2020. The report shall include the name and location of grant recipients, the amount of each grant, the services provided, and the

effects on the foster care system. The commissioner shall determine the form required for the report and may specify additional reporting requirements.

Subd. 5. **Funding.** The commissioner of human services may use available parent support outreach program funds for foster care recruitment grants under Minnesota Statutes, section 260C.216.

Sec. 35. **[260C.218] PARENT SUPPORT FOR BETTER OUTCOMES GRANTS.**

The commissioner of human services may use available parent support outreach program funds to provide mentoring, guidance, and support services to parents navigating the child welfare system in Minnesota, in order to promote the development of safe, stable, and healthy families, including parent mentoring, peer-to-peer support groups, housing support services, training, staffing, and administrative costs.

Sec. 36. Minnesota Statutes 2018, section 518A.32, subdivision 3, is amended to read:

Subd. 3. **Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis.** A parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis upon a showing by the parent that:

(1) the unemployment, underemployment, or employment on a less than full-time basis is temporary and will ultimately lead to an increase in income;

(2) the unemployment, underemployment, or employment on a less than full-time basis represents a bona fide career change that outweighs the adverse effect of that parent's diminished income on the child; or

(3) the unemployment, underemployment, or employment on a less than full-time basis is because a parent is physically or mentally incapacitated or due to incarceration~~, except where the reason for incarceration is the parent's nonpayment of support~~.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 37. Minnesota Statutes 2018, section 518A.51, is amended to read:

518A.51 FEES FOR IV-D SERVICES.

(a) When a recipient of IV-D services is no longer receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs, the public authority responsible for child support enforcement must notify the recipient, within five working days of the notification of ineligibility, that IV-D services will be continued unless the public authority

is notified to the contrary by the recipient. The notice must include the implications of continuing to receive IV-D services, including the available services and fees, cost recovery fees, and distribution policies relating to fees.

(b) In the case of an individual who has never received assistance under a state program funded under title IV-A of the Social Security Act and for whom the public authority has collected at least ~~$500~~ $550 of support, the public authority must impose an annual federal collections fee of ~~$25~~ $35 for each case in which services are furnished. This fee must be retained by the public authority from support collected on behalf of the individual, but not from the first ~~$500~~ $550 collected.

(c) When the public authority provides full IV-D services to an obligee who has applied for those services, upon written notice to the obligee, the public authority must charge a cost recovery fee of two percent of the amount collected. This fee must be deducted from the amount of the child support and maintenance collected and not assigned under section 256.741 before disbursement to the obligee. This fee does not apply to an obligee who:

(1) is currently receiving assistance under the state's title IV-A, IV-E foster care, or medical assistance programs; or

(2) has received assistance under the state's title IV-A or IV-E foster care programs, until the person has not received this assistance for 24 consecutive months.

(d) When the public authority provides full IV-D services to an obligor who has applied for such services, upon written notice to the obligor, the public authority must charge a cost recovery fee of two percent of the monthly court-ordered child support and maintenance obligation. The fee may be collected through income withholding, as well as by any other enforcement remedy available to the public authority responsible for child support enforcement.

(e) Fees assessed by state and federal tax agencies for collection of overdue support owed to or on behalf of a person not receiving public assistance must be imposed on the person for whom these services are provided. The public authority upon written notice to the obligee shall assess a fee of $25 to the person not receiving public assistance for each successful federal tax interception. The fee must be withheld prior to the release of the funds received from each interception and deposited in the general fund.

(f) Federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d) retained by the commissioner of human services shall be considered child support program income according to Code of Federal Regulations, title 45, section 304.50, and shall be deposited in the special revenue fund account established

under paragraph (h). The commissioner of human services must elect to recover costs based on either actual or standardized costs.

(g) The limitations of this section on the assessment of fees shall not apply to the extent inconsistent with the requirements of federal law for receiving funds for the programs under title IV-A and title IV-D of the Social Security Act, United States Code, title 42, sections 601 to 613 and United States Code, title 42, sections 651 to 662.

(h) The commissioner of human services is authorized to establish a special revenue fund account to receive the federal collections fees collected under paragraph (b) and cost recovery fees collected under paragraphs (c) and (d).

(i) The nonfederal share of the cost recovery fee revenue must be retained by the commissioner and distributed as follows:

(1) one-half of the revenue must be transferred to the child support system special revenue account to support the state's administration of the child support enforcement program and its federally mandated automated system;

(2) an additional portion of the revenue must be transferred to the child support system special revenue account for expenditures necessary to administer the fees; and

(3) the remaining portion of the revenue must be distributed to the counties to aid the counties in funding their child support enforcement programs.

(j) The nonfederal share of the federal collections fees must be distributed to the counties to aid them in funding their child support enforcement programs.

(k) The commissioner of human services shall distribute quarterly any of the funds dedicated to the counties under paragraphs (i) and (j) using the methodology specified in section 256.979, subdivision 11. The funds received by the counties must be reinvested in the child support enforcement program and the counties must not reduce the funding of their child support programs by the amount of the funding distributed.

EFFECTIVE DATE. This section is effective October 1, 2019.

Sec. 38. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TEFRA OPTION IMPROVEMENT MEASURES.**

(a) The commissioner of human services shall, using existing appropriations, develop content to be included on the MNsure website explaining the TEFRA option under medical assistance for applicants who indicate during the application process that a child in the family has a disability.

(b) The commissioner shall develop a cover letter explaining the TEFRA option under medical assistance, as well as the application and renewal process, to be disseminated with the DHS-6696A form to applicants who may qualify for medical assistance under the TEFRA option. The commissioner shall provide the content and the form to the executive director of MNsure for inclusion on the MNsure website. The commissioner shall also develop and implement education and training for lead agency staff statewide to improve understanding of the medical assistance-TEFRA enrollment and renewal processes and procedures.

(c) The commissioner shall convene a stakeholder group that shall consider improvements to the TEFRA option enrollment and renewal processes, including but not limited to revisions to, or the development of, application and renewal paperwork specific to the TEFRA option; possible technology solutions; and county processes.

(d) The stakeholder group must include representatives from the Department of Human Services Health Care Division, MNsure, representatives from at least two counties in the metropolitan area and from at least one county in greater Minnesota, the Arc Minnesota, Gillette Children's Specialty Healthcare, the Autism Society of Minnesota, Proof Alliance, the Minnesota Consortium for Citizens with Disabilities, and other interested stakeholders as identified by the commissioner of human services.

(e) The stakeholder group shall submit a report of the group's recommended improvements and any associated costs to the commissioner by December 31, 2020. The group shall also provide copies of the report to each stakeholder group member. The commissioner shall provide a copy of the report to the legislative committees with jurisdiction over medical assistance.

Sec. 39. **MINNESOTA PATHWAYS TO PROSPERITY AND WELL-BEING PILOT PROJECT.**

Subdivision 1. **Authorization.** (a) The commissioner of human services shall develop a pilot project that tests an alternative benefit delivery system for the distribution of public assistance benefits. The commissioner shall work with Dakota County and Olmsted County to develop the pilot project in accordance with this section. The commissioner shall apply for any federal waivers necessary to implement the pilot project.

(b) Prior to authorizing the pilot project, Dakota and Olmsted Counties must provide the following information to the commissioner:

(1) identification of any federal waivers required to implement the pilot project and a timeline for obtaining the waivers;

(2) identification of data sharing requirements between the counties and the commissioner to administer the pilot project and evaluate the outcome measures under subdivision 4, including the technology systems that will be developed to administer the pilot project and a description of the elements of the technology systems that will ensure the privacy of the data of the participants and provide financial oversight and accountability for expended funds;

(3) documentation that demonstrates receipt of private donations or grants totaling at least $2,800,000 per year for three years to support implementation of the pilot project;

(4) a complete plan for implementing the pilot project, including an assurance that each participant's unified benefit amount is proportionate to and in no event exceeds the total amount that the participant would have received by participating in the underlying programs for which they are eligible upon entering the pilot project, information about the administration of the unified benefit amount to ensure that the benefit is used by participants for the services provided through the underlying programs included in the unified benefit, an explanation of which funds will be issued directly to providers and which funds will be available on an EBT card, and information about consequences and remedies for improper use of the unified benefit;

(5) an evaluation plan developed in consultation with the commissioner of management and budget to ensure that the pilot project includes an evaluation using an experimental or quasi-experimental design and a formal evaluation of the results of the pilot project; and

(6) documentation that demonstrates the receipt of a formal commitment of grants or contracts with the federal government to complete a comprehensive evaluation of the pilot project.

(c) The commissioner may authorize the pilot project only after reviewing the information submitted under paragraph (b) and issuing a formal written approval of the proposed project.

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 may receive public assistance;

(2) eliminate, where possible, regulatory or program restrictions to allow a comprehensive approach to meeting the needs of the families in the pilot project; and

(3) focus on prevention-oriented supports and interventions.

Subd. 3. **Pilot project participants.** The pilot project developed by the commissioner must include requirements that participants:

(1) be 30 years of age or younger with a minimum of one child and income below 200 percent of federal poverty guidelines;

(2) voluntarily agree to participate in the pilot project;

(3) be informed of the right to voluntarily discontinue participation in the pilot project;

(4) be eligible for or receiving assistance under the Minnesota family investment program under Minnesota Statutes, chapter 256J, and at least one of the following programs: (i) the child care assistance program under Minnesota Statutes, chapter 119B; (ii) the diversionary work program under Minnesota Statutes, section 256J.95; (iii) the supplemental nutrition assistance program under Minnesota Statutes, chapter 256D; or (iv) state or federal housing support;

(5) provide informed, written consent that the participant waives eligibility for the programs included in the unified benefit set for the duration of their participation in the pilot project;

(6) be enrolled in an education program that is focused on obtaining a career that will result in a livable wage;

(7) receive as the unified benefit only an amount that is proportionate to and does not exceed the total value of the benefits the participant would be eligible to receive under the underlying programs upon entering the pilot project; and

(8) shall not have the unified benefit amount counted as income for child support or tax purposes.

Subd. 4. **Outcomes.** (a) The outcome measures for the pilot project must be developed in consultation with the commissioner of management and budget, and must include:

(1) improvement in the affordability, safety, and permanence of suitable housing;

(2) improvement in family functioning and stability, including the areas of behavioral health, incarceration, involvement with the child welfare system;

(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, grade point average, and standardized test improvement;

(4) improvement in attachment to the workforce of one or both parents, including enhanced job stability; wage gains; career advancement; and progress in career preparation; and

(5) improvement in health care access and health outcomes for parents and children and other outcomes determined in consultation with the commissioner of human services and the commissioner of management and budget.

(b) Dakota and Olmsted Counties shall report on the progress and outcomes of the pilot project to the chairs and ranking minority members of the legislative committees with jurisdiction over human services by January 15 of each year that the pilot project operates, beginning January 15, 2021.

Sec. 40. **DIRECTION TO COMMISSIONER; CHILD CARE ASSISTANCE PROGRAM REDESIGN.**

(a) By January 15, 2020, the commissioner of human services shall, following consultation with families, providers, and county agencies, report to the chairs and ranking minority members of the legislative committees having jurisdiction over child care with a proposal, for implementation by July 1, 2020, that redesigns the child care assistance program to meet all applicable federal requirements, achieve at least the following objectives, and include at least the following features:

(1) eliminates fraud;

(2) eliminates program inefficiencies;

(3) eliminates barriers to families entering the program;

(4) improves accessibility to child care for families in greater Minnesota and in the metropolitan area;

(5) improves the quality of available child care;

(6) eliminates assistance rate disparities between greater Minnesota and the metropolitan area;

(7) ensures future access to assistance and child care for families in greater Minnesota and in the metropolitan area;

(8) develops additional options for providers to complete required training including through online or remote access;

(9) improves ease of provider access to required training and quality improvement resources;

(10) reforms the Parent Aware program, including by removing barriers to participation for family child care providers, by implementing a method for evaluating the quality and

effectiveness of four-star rated programs, and by incorporating licensing violations, sanctions, or maltreatment determinations into the star-rating program standards;

(11) proposes legislation that codifies Parent Aware program standards;

(12) implements a licensing and inspection structure based on differential monitoring;

(13) amends licensing requirements that have led to closure of child care programs, especially family child care programs;

(14) recommends business development and technical assistance resources to promote provider recruitment and retention;

(15) allows for family child care licensing alternatives, including permitting multiple family child care providers to operate in a commercial or other building other than the providers' residences; and

(16) improves family child care licensing efficiencies, including by adding a variance structure and updating child ratios.

(b) The commissioner shall seek all necessary federal waivers to implement the proposed redesign described in paragraph (a), including to authorize use of existing federal funding.

Sec. 41. **DIRECTION TO COMMISSIONER; ABBREVIATED INSPECTION MODEL.**

(a) By January 1, 2020, the commissioner of human services shall, following consultation with family child care license holders, parents, and county agencies, develop the key indicators for use in the abbreviated inspection process under Minnesota Statutes, section 245A.055, subdivision 2, paragraph (c), and report the results to the chairs and ranking minority members of the legislative committees with jurisdiction over child care. In developing the key indicators that predict full compliance with the statutes and rules governing licensed child care providers, the commissioner shall utilize an empirically based statistical methodology similar to the licensing key indicator systems as developed by the National Association for Regulatory Administration and the Research Institute for Key Indicators.

(b) By July 1, 2020, the commissioner of human services shall develop, distribute, and provide training to implement abbreviated inspections as described in Minnesota Statutes, section 245A.055, subdivision 2, paragraph (c).

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 42. **DIRECTION TO COMMISSIONER; CHILD CARE TRAINING REQUIREMENTS.**

(a) The commissioner of human services shall develop an annual refresher course as described in Minnesota Statutes, section 245A.50, subdivision 12, for child care providers who previously completed the training requirements under Minnesota Statutes, chapter 245A.

(b) The commissioner must propose any necessary legislative changes to develop and implement the annual refresher training course in paragraph (a) and to eliminate duplicative training requirements for the 2020 legislative session.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 43. **DIRECTION TO COMMISSIONER; CORRECTION ORDER ENFORCEMENT REVIEW.**

By January 1, 2020, the commissioner of human services shall develop and implement a process to review licensing inspection results provided under Minnesota Statutes, section 245A.16, subdivision 1, paragraph (h), clause (1), by county to identify trends in correction order enforcement. The commissioner shall develop guidance and training as needed to address any imbalance or inaccuracy in correction order enforcement. The commissioner shall include the results in the annual report on child care under Minnesota Statutes, section 245A.153, provided that the results are limited to summary data as defined in Minnesota Statutes, section 13.02, subdivision 19.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 44. **DIRECTION TO COMMISSIONER; SUBSTITUTE CAREGIVER PERMISSION.**

(a) The commissioner of human services shall amend Minnesota Rules, part 9502.0365, subpart 5, to permit licensed providers to use substitute caregivers for a cumulative total of 720 hours in any 12-month period.

(b) The commissioner of human services may use the good cause exemption under Minnesota Statutes, section 14.388, subdivision 1, clause (3), to adopt rules under this section, and Minnesota Statutes, section 14.386, does not apply except as provided under Minnesota Statutes, section 14.388.

Sec. 45. **FAMILY CHILD CARE TASK FORCE.**

Subdivision 1. **Membership.** (a) The Family Child Care Task Force shall consist of 14 members, appointed as follows:

(1) two members representing family child care providers from greater Minnesota, including one appointed by the speaker of the house of representatives and one appointed by the senate majority leader;

(2) two members representing family care providers from the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2, including one appointed by the speaker of the house of representatives and one appointed by the senate majority leader;

(3) two members appointed by the Minnesota Association of Child Care Professionals;

(4) two members appointed by the Minnesota Child Care Provider Information Network;

(5) two members representing Department of Human Services-recognized family child care associations from greater Minnesota, including one appointed by the senate majority leader and one appointed by the senate minority leader;

(6) two members appointed by the Association of Minnesota Child Care Licensors, including one from greater Minnesota and one from the metropolitan area, as defined in Minnesota Statutes, section 473.121, subdivision 2;

(7) one member appointed by the Greater Minnesota Partnership; and

(8) one member appointed by the Minnesota Chamber of Commerce.

(b) Appointments to the task force must be made by June 15, 2019.

Subd. 2. **Compensation.** Public members of the task force may be compensated as provided by Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force must:

(1) identify difficulties that providers face regarding licensing and inspection, including licensing requirements that have led to the closure of family child care programs; propose regulatory reforms to improve licensing efficiency, including a variance structure and updated child ratios; and recommend business development and technical assistance resources to promote provider recruitment and retention;

(2) identify alternative family child care business models, including permitting multiple family child care providers to operate in a building other than the providers' residences; and

(3) review Parent Aware program participation and identify obstacles and suggested improvements.

Subd. 4. **Officers; meetings.** (a) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(b) The task force must meet at least three times. The commissioner of human services must convene the first meeting by August 1, 2019, at which the task force must at least make introductions, identify concerns of the members and issues related to the duties under subdivision 4, and assign tasks for each member to complete before the second meeting. The chair must convene the second meeting by November 1, 2019, at which the task force must at least review members' work on the tasks from the first meeting and develop a plan for members to create proposals relating to the duties of the task force under subdivision 4. The chair must convene the third meeting by February 1, 2020, at which the task force must at least discuss which of the members' proposals to include in its final report.

(c) In accordance with paragraph (b), the agenda for each meeting must be determined by the chair and vice-chair.

(d) Meetings of the task force are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Administrative support.** The division of child care licensing in the Department of Human Services must provide administrative support and meeting space to support the task force as needed.

Subd. 6. **Report required.** By March 1, 2020, the task force must submit a written report to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over child care. The report must include:

(1) a description of the difficulties that providers face regarding licensing and inspection, and recommendations for addressing those difficulties;

(2) a description of alternative family child care business models, and recommendations for facilitating the delivery of child care through those alternative models;

(3) a description of obstacles to participation in the Parent Aware program and recommendations for increasing participation; and

(4) any draft legislation necessary to implement the recommendations.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6 or March 1, 2020, whichever is later.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 46. **INSTRUCTION TO COMMISSIONER; REVIEW OF CHILD CARE LICENSING AND BACKGROUND STUDY PROVISIONS.**

The commissioner of human services shall review existing statutes and rules relating to child care licensing and background study requirements and propose legislation for the 2020 legislative session that eliminates unnecessary and duplicative record keeping or documentation requirements for child care providers. The commissioner shall also establish a process for child care providers to electronically submit requested information to the commissioner.

Sec. 47. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with the Department of Human Services, House Research Department, and Senate Counsel, Research and Fiscal Analysis shall change the terms "food support" and "food stamps" to "Supplemental Nutrition Assistance Program" or "SNAP" in Minnesota Statutes when appropriate. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text.

Sec. 48. **REVISOR INSTRUCTION.**

The revisor of statutes shall remove the terms "child care assistance program," "basic sliding fee child care," and "MFIP child care," or similar terms wherever the terms appear in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 49. **REVISOR INSTRUCTION; MINNESOTA RULES, CHAPTER 9502.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services shall prepare legislation for the 2020 legislative session to repeal and enact as statutes Minnesota Rules, chapter 9502, and recodify Minnesota Statutes sections governing licensing of child care facilities. The revisor of statutes shall provide a courtesy copy of the proposed legislation to the chief authors in the house of representatives and senate of this act.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 50. **REVISOR INSTRUCTION; MINNESOTA RULES, CHAPTER 9503.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and the Department of Human Services shall prepare legislation for the 2020 legislative session to repeal and enact as statutes Minnesota Rules, chapter 9503, and recodify Minnesota Statutes sections governing licensing of child care facilities. The revisor of statutes shall provide a courtesy copy of the proposed legislation to the chief authors in the house of representatives and senate of this act.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 51. **REVISOR INSTRUCTION; RECODIFY MINNESOTA STATUTES, CHAPTER 245A; RECODIFY MINNESOTA RULES, CHAPTER 9502.**

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall prepare legislation for the 2020 legislative session to: (1) recodify Minnesota Statutes, chapter 245A; and (2) repeal and enact as statutes the rules governing day care facility licensing in Minnesota Rules, chapter 9502.

Sec. 52. **REPEALER.**

(a) Minnesota Statutes 2018, sections 119B.011, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10a, 11, 12, 13, 13a, 14, 15, 16, 17, 18, 19, 19a, 19b, 20, 20a, 21, and 22; 119B.02; 119B.025, subdivisions 1, 2, 3, and 4; 119B.03, subdivisions 1, 2, 3, 4, 5, 6, 6a, 6b, 8, 9, and 10; 119B.035; 119B.04; 119B.05, subdivisions 1, 4, and 5; 119B.06, subdivisions 1, 2, and 3; 119B.08, subdivisions 1, 2, and 3; 119B.09, subdivisions 1, 3, 4, 4a, 5, 6, 7, 8, 9, 9a, 10, 11, 12, and 13; 119B.095; 119B.097; 119B.10, subdivisions 1, 2, and 3; 119B.105; 119B.11, subdivisions 1, 2a, 3, and 4; 119B.12, subdivisions 1 and 2; 119B.125; 119B.13, subdivisions 1, 1a, 3, 3a, 3b, 3c, 4, 5, 6, and 7; 119B.14; 119B.15; and 119B.16, are repealed effective July 1, 2020.

(b) Minnesota Rules, parts 3400.0010; 3400.0020, subparts 1, 4, 5, 8, 9a, 10a, 12, 17a, 18, 18a, 20, 24, 25, 26, 28, 29a, 31b, 32b, 33, 34a, 35, 37, 38, 38a, 38b, 39, 40, 40a, and 44; 3400.0030; 3400.0035; 3400.0040, subparts 1, 3, 4, 5, 5a, 6a, 6b, 6c, 7, 8, 9, 10, 11, 12, 13, 14, 15, 15a, 17, and 18; 3400.0060, subparts 2, 4, 5, 6, 6a, 7, 8, 9, and 10; 3400.0080, subparts 1, 1a, 1b, and 8; 3400.0090, subparts 1, 2, 3, and 4; 3400.0100, subparts 2a, 2b, 2c, and 5; 3400.0110, subparts 1, 1a, 2, 2a, 3, 4a, 7, 8, 9, 10, and 11; 3400.0120, subparts 1, 1a, 2, 2a, 3, and 5; 3400.0130, subparts 1, 1a, 2, 3, 3a, 3b, 5, 5a, and 7; 3400.0140, subparts 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,

and 11; 3400.0180; 3400.0183, subparts 1, 2, and 5; 3400.0185; 3400.0187, subparts 1, 2, 3, 4, and 6; 3400.0200; 3400.0220; 3400.0230, subpart 3; and 3400.0235, subparts 1, 2, 3, 4, 5, and 6, are repealed are effective July 1, 2020.

(c) Laws 2017, First Special Session chapter 6, article 7, section 34, is repealed effective July 1, 2019.

ARTICLE 3
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2018, section 13.851, is amended by adding a subdivision to read:

Subd. 11. **Mental health data sharing.** Section 641.15, subdivision 3a, governs the sharing of data on prisoners who may have a mental illness or need services with county social service agencies or welfare system personnel.

Sec. 2. **[245.4663] OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants to programs that provide officer-involved community-based care coordination services under section 256B.0625, subdivision 56a. The commissioner shall balance awarding grants to counties outside the metropolitan area and counties inside the metropolitan area.

(b) The commissioner shall provide outreach, technical assistance, and program development support to increase capacity of new and existing officer-involved community-based care coordination programs, particularly in areas where officer-involved community-based care coordination programs have not been established, especially in greater Minnesota.

(c) Funds appropriated for this section must be expended on activities described under subdivision 3, technical assistance, and capacity building, including the capacity to maximize revenue by billing services to available third-party reimbursement sources, in order to meet the greatest need on a statewide basis.

Subd. 2. **Eligibility.** An eligible applicant for an officer-involved community-based care coordination grant under subdivision 1, paragraph (a), is a county or tribe that operates or is prepared to implement an officer-involved community-based care coordination program.

Subd. 3. **Allowable grant activities.** Grant recipients may use grant funds for the costs of providing officer-involved community-based care coordination services that are not

otherwise covered under section 256B.0625, subdivision 56a, and for the cost of services for individuals not eligible for medical assistance.

Subd. 4. **Reporting.** (a) The commissioner shall report annually on the use of officer-involved community-based care coordination grants to the legislative committees with jurisdiction over human services by December 31, beginning in 2020. Each report shall include the name and location of the grant recipients, the amount of each grant, the services provided or planning activities conducted, and the number of individuals receiving services. The commissioner shall determine the form required for the reports and may specify additional reporting requirements.

(b) The reporting requirements under this subdivision are in addition to the reporting requirements under section 256B.0625, subdivision 56a, paragraph (e).

Sec. 3. Minnesota Statutes 2018, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement, whether or not the child is receiving case management services;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services, including transportation for children receiving school-linked mental health services when school is not in session;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; ~~and~~

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants~~.~~; and

(18) promoting and developing a provider's capacity to deliver multigenerational mental health treatment and services.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

Sec. 4. Minnesota Statutes 2018, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for substance use disorder care.** (a) The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care for each recipient of public assistance seeking treatment for substance misuse or substance use disorder. Upon federal approval of a comprehensive assessment as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of

comprehensive assessments under section 254B.05 may determine and approve the appropriate level of substance use disorder treatment for a recipient of public assistance. The process for determining an individual's financial eligibility for the consolidated chemical dependency treatment fund or determining an individual's enrollment in or eligibility for a publicly subsidized health plan is not affected by the individual's choice to access a comprehensive assessment for placement.

(b) The commissioner shall develop and implement a utilization review process for publicly funded treatment placements to monitor and review the clinical appropriateness and timeliness of all publicly funded placements in treatment.

(c) If a screen result is positive for alcohol or substance misuse, a brief screening for alcohol or substance use disorder that is provided to a recipient of public assistance within a primary care clinic, hospital, or other medical setting or school setting establishes medical necessity and approval for an initial set of substance use disorder services identified in section 254B.05, subdivision 5. The initial set of services approved for a recipient whose screen result is positive may include four hours of individual or group substance use disorder treatment, two hours of substance use disorder treatment coordination, or two hours of substance use disorder peer support services provided by a qualified individual according to chapter 245G. A recipient must obtain an assessment pursuant to paragraph (a) to be approved for additional treatment services.

EFFECTIVE DATE. Contingent upon federal approval, this section is effective July 1, 2019. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 5. Minnesota Statutes 2018, section 254A.19, is amended by adding a subdivision to read:

Subd. 5. **Assessment via telemedicine.** Notwithstanding Minnesota Rules, part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via telemedicine.

Sec. 6. Minnesota Statutes 2018, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder~~

~~of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 7. Minnesota Statutes 2018, section 254B.03, subdivision 2, is amended to read:

Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor is prohibited from using the client's public benefits to offset the cost of services paid under this section. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors ~~certified according to~~ meeting the criteria under section 254B.05, subdivision 1a, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for

payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. ~~The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services~~ The commissioner may deny vendor certification to a provider if the commissioner determines that the services currently available in the local area are sufficient to meet local need and that the addition of new services would be detrimental to individuals seeking these services.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 8. Minnesota Statutes 2018, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for 22.95 percent of the cost of chemical dependency services, ~~including those~~ except that the county shall pay the state for ten percent of the nonfederal share of the cost of chemical dependency services provided to persons ~~eligible for~~ enrolled in medical assistance under chapter 256B, and ten percent of the cost of room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12). Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) 22.95 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

~~(c) For fiscal year 2017 only, the 22.95 percentages under paragraphs (a) and (b) are equal to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 9. Minnesota Statutes 2018, section 254B.04, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, ~~and persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or~~ who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (12).

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 10. Minnesota Statutes 2018, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000, vendors of room and board are eligible for chemical dependency fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 11. Minnesota Statutes 2018, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system,~~

~~billing, and collections.~~ The remaining receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 12. Minnesota Statutes 2018, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** ~~(a) The commissioner shall allocate all federal financial participation collections to a special revenue account.~~ The commissioner shall allocate 77.05 percent of patient payments and third-party payments to the special revenue account and 22.95 percent to the county financially responsible for the patient.

~~(b) For fiscal year 2017 only, the commissioner's allocation to the special revenue account shall be increased from 77.05 percent to 79.8 percent and the county financial responsibility shall be reduced from 22.95 percent to 20.2 percent.~~

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 24, is amended to read:

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law~~, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B~~. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 14. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 24a. **Substance use disorder services.** Medical assistance covers substance use disorder treatment services according to section 254B.05, subdivision 5, except for room and board.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 15. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination for an individual who:

(1) has ~~been identified as having~~ screened positive for benefiting from treatment for a mental illness or substance use disorder using a ~~screening~~ tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination ~~through a diversion contract in lieu of incarceration~~.

(b) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination must be provided by an individual who is an employee of ~~a county~~ or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide ~~post-arrest~~ officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; ~~or~~

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional~~.~~;

(4) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(5) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

~~(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.~~

Sec. 16. Minnesota Statutes 2018, section 256B.0757, subdivision 1, is amended to read:

Subdivision 1. **Provision of coverage.** (a) The commissioner shall provide medical assistance coverage of health home services for eligible individuals with chronic conditions who select a designated provider as the individual's health home.

(b) The commissioner shall implement this section in compliance with the requirements of the state option to provide health homes for enrollees with chronic conditions, as provided under the Patient Protection and Affordable Care Act, Public Law 111-148, sections 2703 and 3502. Terms used in this section have the meaning provided in that act.

(c) The commissioner shall establish health homes to serve populations with serious mental illness who meet the eligibility requirements described under subdivision 2~~, clause (4)~~. The health home services provided by health homes shall focus on both the behavioral and the physical health of these populations.

Sec. 17. Minnesota Statutes 2018, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has ~~at least:~~

~~(1) two chronic conditions;~~

~~(2) one chronic condition and is at risk of having a second chronic condition;~~

~~(3) one serious and persistent mental health condition; or~~

~~(4)~~ a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871, subdivision 15, clause (2)~~; and has a current diagnostic assessment as defined in Minnesota Rules, part 9505.0372, subpart 1, item B or C, as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home~~. The commissioner shall establish criteria for determining continued eligibility.

Sec. 18. Minnesota Statutes 2018, section 256B.0757, subdivision 4, is amended to read:

Subd. 4. **Designated provider.** ~~(a)~~ Health home services are voluntary and an eligible individual may choose any designated provider. The commissioner shall establish designated providers to serve as health homes and provide the services described in subdivision 3 to individuals eligible under subdivision 2. The commissioner shall apply for grants as provided under section 3502 of the Patient Protection and Affordable Care Act to establish health homes and provide capitated payments to designated providers. For purposes of this section, "designated provider" means a provider, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or any other entity that is determined by the commissioner to be qualified to be a health home for eligible individuals. This determination must be based on documentation evidencing that the designated provider has the systems and infrastructure in place to provide health home services and satisfies the qualification standards established by the commissioner in consultation with stakeholders and approved by the Centers for Medicare and Medicaid Services.

~~(b) The commissioner shall develop and implement certification standards for designated providers under this subdivision.~~

Sec. 19. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 9. **Discharge criteria.** (a) An individual may be discharged from behavioral health home services if:

(1) the behavioral health home services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or

(2) the individual is unwilling to participate in behavioral health home services as demonstrated by the individual's refusal to meet with the behavioral health home services provider, or refusal to identify the individual's goals or the activities or support necessary to achieve the individual's health and wellness goals.

(b) Before discharge from behavioral health home services, the behavioral health home services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the behavioral health home services provider to discuss options available to the individual, including maintaining behavioral health home services.

Sec. 20. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 10. **Behavioral health home services provider requirements.** A behavioral health home services provider must:

(1) be an enrolled Minnesota Health Care Programs provider;

(2) provide a medical assistance covered primary care or behavioral health service;

(3) utilize an electronic health record;

(4) utilize an electronic patient registry that contains data elements required by the commissioner;

(5) demonstrate the organization's capacity to administer screenings approved by the commissioner for substance use disorder or alcohol and tobacco use;

(6) demonstrate the organization's capacity to refer an individual to resources appropriate to the individual's screening results;

(7) have policies and procedures to track referrals to ensure that the referral met the individual's needs;

(8) conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services;

(9) conduct a health wellness assessment within 60 days after intake that contains all required elements identified by the commissioner;

(10) conduct a health action plan that contains all required elements identified by the commissioner within 90 days after intake and updated at least once every six months or more frequently if significant changes to an individual's needs or goals occur;

(11) agree to cooperate and participate with the state's monitoring and evaluation of behavioral health home services; and

(12) utilize the form approved by the commissioner to obtain the individual's written consent to begin receiving behavioral health home services.

Sec. 21. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 11. **Provider training and practice transformation requirements.** (a) The behavioral health home services provider must ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training including:

(1) training approved by the commissioner that describes the goals and principles of behavioral health home services; and

(2) training on evidence-based practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to reach the individual's health and wellness goals.

(b) The behavioral health home services provider must ensure that staff are capable of implementing culturally responsive services as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.

(c) The behavioral health home services provider must participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

Sec. 22. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 12. **Staff qualifications.** (a) A behavioral health home services provider must maintain staff with required professional qualifications appropriate to the setting.

(b) If behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.285.

(c) If behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

(d) If behavioral health home services are offered in either a primary care setting or mental health setting, the systems navigator must be a mental health practitioner as defined in section 245.462, subdivision 17, or a community health worker as defined in section 256B.0625, subdivision 49.

(e) If behavioral health home services are offered in either a primary care setting or mental health setting, the qualified health home specialist must be one of the following:

(1) a peer support specialist as defined in section 256B.0615;

(2) a family peer support specialist as defined in section 256B.0616;

(3) a case management associate as defined in section 245.462, subdivision 4, paragraph (g), or 245.4871, subdivision 4, paragraph (j);

(4) a mental health rehabilitation worker as defined in section 256B.0623, subdivision 5, clause (4);

(5) a community paramedic as defined in section 144E.28, subdivision 9;

(6) a peer recovery specialist as defined in section 245G.07, subdivision 1, clause (5); or

(7) a community health worker as defined in section 256B.0625, subdivision 49.

Sec. 23. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 13. **Service delivery standards.** (a) A behavioral health home services provider must meet the following service delivery standards:

(1) establish and maintain processes to support the coordination of an individual's primary care, behavioral health, and dental care;

(2) maintain a team-based model of care, including regular coordination and communication between behavioral health home services team members;

(3) use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices;

(4) use person-centered planning practices to ensure the individual's health action plan accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the individual's identified supports;

(5) use the patient registry to identify individuals and population subgroups requiring specific levels or types of care and provide or refer the individual to needed treatment, intervention, or service;

(6) utilize Department of Human Services Partner Portal to identify past and current treatment or services and to identify potential gaps in care;

(7) deliver services consistent with standards for frequency and face-to-face contact as required by the commissioner;

(8) ensure that all individuals receiving behavioral health home services have a diagnostic assessment completed within six months of when the individual begins receiving behavioral health home services;

(9) deliver services in locations and settings that meet the needs of the individual;

(10) provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being;

(11) have capacity to assess an individual's readiness for change and the individual's capacity to integrate new health care or community supports into the individual's life;

(12) offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions;

(13) help an individual set up and prepare for appointments, including accompanying the individual to appointments as appropriate, and follow up with the individual after medical, behavioral health, social service, or community support appointments;

(14) offer or facilitate the provision of health coaching related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports;

(15) connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

(16) provide effective referrals and timely access to services; and

(17) establish a continuous quality improvement process for providing behavioral health home services.

(b) The behavioral health home services provider must also create a plan, in partnership with the individual and the individual's identified supports, to support the individual after discharge from a hospital, residential treatment program, or other setting. The plan must include protocols for:

(1) maintaining contact between the behavioral health home services team member and the individual and the individual's identified supports during and after discharge;

(2) linking the individual to new resources as needed;

(3) reestablishing the individual's existing services and community and social supports; and

(4) following up with appropriate entities to transfer or obtain the individual's service records as necessary for continued care.

(c) If the individual is enrolled in a managed care plan, a behavioral health home services provider must:

(1) notify the behavioral health home services contact designated by the managed care plan within 30 days of when the individual begins behavioral health home services; and

(2) adhere to the managed care plan communication and coordination requirements described in the behavioral health home services manual.

(d) Before terminating behavioral health home services, the behavioral health home services provider must:

(1) provide a 60-day notice of termination of behavioral health home services to all individuals receiving behavioral health home services, the department, and managed care plans, if applicable; and

(2) refer individuals receiving behavioral health home services to a new behavioral health home services provider.

Sec. 24. Minnesota Statutes 2018, section 256B.0757, is amended by adding a subdivision to read:

Subd. 14. **Provider variances.** (a) The commissioner may grant a variance to specific requirements under subdivision 10, 11, 12, or 13 for a behavioral health home services provider according to this subdivision.

(b) The commissioner may grant a variance if the commissioner finds that (1) failure to grant the variance would result in hardship or injustice to the applicant, (2) the variance would be consistent with the public interest, and (3) the variance would not reduce the level of services provided to individuals served by the organization.

(c) The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative if the commissioner finds that the variance does not impede the achievement of the criteria in subdivision 10, 11, 12, or 13 and may improve the behavioral health home services provided by the applicant.

(d) The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

Sec. 25. **[256B.0759] SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.**

Subdivision 1. **Establishment.** The commissioner shall develop and implement a medical assistance demonstration project to test reforms of Minnesota's substance use disorder treatment system to ensure individuals with substance use disorders have access to a full continuum of high quality care.

Subd. 2. **Provider participation.** Substance use disorder treatment providers may elect to participate in the demonstration project and fulfill the requirements under subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider.

Subd. 3. **Provider standards.** (a) The commissioner shall establish requirements for participating providers that are consistent with the federal requirements of the demonstration project.

(b) Participating residential providers must obtain applicable licensure under chapters 245F, 245G, or other applicable standards for the services provided and must:

(1) deliver services in accordance with American Society of Addiction Medicine (ASAM) standards;

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards; and

(3) provide or arrange for medication-assisted treatment services if requested by a client for whom an effective medication exists.

(c) Participating outpatient providers must be licensed and must:

(1) deliver services in accordance with ASAM standards; and

(2) maintain formal patient referral arrangements with providers delivering step-up or step-down levels of care in accordance with ASAM standards.

(d) If the provider standards under chapter 245G or other applicable standards conflict or are duplicative, the commissioner may grant variances to the standards if the variances do not conflict with federal requirements. The commissioner shall publish service components, service standards, and staffing requirements for participating providers that are consistent with ASAM standards and federal requirements.

Subd. 4. **Provider payment rates.** (a) Payment rates for participating providers must be increased for services provided to medical assistance enrollees.

(b) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clause (8), payment rates must be increased by 15 percent over the rates in effect on January 1, 2020.

(c) For substance use disorder services under section 254B.05, subdivision 5, paragraph (b), clauses (1), (6), (7), and (10), payment rates must be increased by ten percent over the rates in effect on January 1, 2021.

Subd. 5. **Federal approval.** The commissioner shall seek federal approval to implement the demonstration project under this section and to receive federal financial participation.

Sec. 26. Minnesota Statutes 2018, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if the agency has approved the setting where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), or (c).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual ~~receives licensed residential crisis stabilization services under section 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive concurrent housing support payments if receiving licensed residential crisis stabilization services under section 256B.0624, subdivision 7.~~ lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 27. Minnesota Statutes 2018, section 256I.04, subdivision 2f, is amended to read:

Subd. 2f. **Required services.** (a) In licensed and registered settings under subdivision 2a, providers shall ensure that participants have at a minimum:

(1) food preparation and service for three nutritional meals a day on site;

(2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

(3) housekeeping, including cleaning and lavatory supplies or service; and

(4) maintenance and operation of the building and grounds, including heat, water, garbage removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair and maintain equipment and facilities.

(b) Providers serving participants described in subdivision 1, paragraph (c), shall assist participants in applying for continuing housing support payments before the end of the eligibility period.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 28. Minnesota Statutes 2018, section 256I.06, subdivision 8, is amended to read:

Subd. 8. **Amount of housing support payment.** (a) The amount of a room and board payment to be made on behalf of an eligible individual is determined by subtracting the individual's countable income under section 256I.04, subdivision 1, for a whole calendar month from the room and board rate for that same month. The housing support payment is determined by multiplying the housing support rate times the period of time the individual was a resident or temporarily absent under section 256I.05, subdivision 1c, paragraph (d).

(b) For an individual with earned income under paragraph (a), prospective budgeting must be used to determine the amount of the individual's payment for the following six-month period. An increase in income shall not affect an individual's eligibility or payment amount until the month following the reporting month. A decrease in income shall be effective the first day of the month after the month in which the decrease is reported.

(c) For an individual who receives ~~licensed residential crisis stabilization services under section 256B.0624, subdivision 7,~~ housing support payments under section 256I.04, subdivision 1, paragraph (c), the ~~amount of~~ housing support payment amount is determined by multiplying the housing support rate times the period of time the individual was a resident.

EFFECTIVE DATE. This section is effective September 1, 2019.

Sec. 29. Minnesota Statutes 2018, section 256K.45, subdivision 2, is amended to read:

Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing for homeless youth, and the level and nature of the needs identified; (2) details about grants made, including shelter-linked youth mental health grants under section 256K.46; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding.

Sec. 30. **[256K.46] SHELTER-LINKED YOUTH MENTAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment and authority.** (a) The commissioner shall award grants to provide mental health services to homeless or sexually exploited youth. To be eligible,

housing providers must partner with community-based mental health practitioners to provide a continuum of mental health services, including short-term crisis response, support for youth in longer-term housing settings, and ongoing relationships to support youth in other housing arrangements in the community for homeless or sexually exploited youth.

(b) The commissioner shall consult with the commissioner of management and budget to identify evidence-based mental health services for youth and give priority in awarding grants to proposals that include evidence-based mental health services for youth.

(c) The commissioner may make two-year grants under this section.

(d) Money appropriated for this section must be expended on activities described under subdivision 4, technical assistance, and capacity building to meet the greatest need on a statewide basis. The commissioner shall provide outreach, technical assistance, and program development support to increase capacity of new and existing service providers to better meet needs statewide, particularly in areas where shelter-linked youth mental health services have not been established, especially in greater Minnesota.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services, unless otherwise indicated.

(c) "Housing provider" means a shelter, housing program, or other entity providing services under the Homeless Youth Act in section 256K.45 and the Safe Harbor for Sexually Exploited Youth Act in section 145.4716.

(d) "Mental health practitioner" has the meaning given in section 245.462, subdivision 17.

(e) "Youth" has the meanings given for "homeless youth," "youth at risk for homelessness," and "runaway" in section 256K.45, subdivision 1a, "sexually exploited youth" in section 260C.007, subdivision 31, and "youth eligible for services" in section 145.4716, subdivision 3.

Subd. 3. **Eligibility.** An eligible applicant for shelter-linked youth mental health grants under subdivision 1 is a housing provider that:

(1) demonstrates that the provider received targeted trauma training focused on sexual exploitation and adolescent experiences of homelessness; and

(2) partners with a community-based mental health practitioner who has demonstrated experience or access to training regarding adolescent development and trauma-informed responses.

Subd. 4. **Allowable grant activities.** (a) Grant recipients may conduct the following activities with community-based mental health practitioners:

(1) develop programming to prepare youth to receive mental health services;

(2) provide on-site mental health services, including group skills and therapy sessions. Grant recipients are encouraged to use evidence-based mental health services;

(3) provide mental health case management, as defined in section 256B.0625, subdivision 20; and

(4) consult, train, and educate housing provider staff regarding mental health. Grant recipients are encouraged to provide staff with access to a mental health crisis line 24 hours a day, seven days a week.

(b) Only after promoting and assisting participants with obtaining health insurance coverage for which the participant is eligible, and only after mental health practitioners bill covered services to medical assistance or health plan companies, grant recipients may use grant funds to fill gaps in insurance coverage for mental health services.

(c) Grant funds may be used for purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees to deliver shelter-linked youth mental health services defined in this subdivision via telemedicine consistent with section 256B.0625, subdivision 3b.

Subd. 5. **Reporting.** Grant recipients shall report annually on the use of shelter-linked youth mental health grants to the commissioner by December 31, beginning in 2020. Each report shall include the name and location of the grant recipient, the amount of each grant, the youth mental health services provided, and the number of youth receiving services. The commissioner shall determine the form required for the reports and may specify additional reporting requirements. The commissioner shall include the shelter-linked youth mental health services program in the biennial report required under section 256K.45, subdivision 2.

Sec. 31. Minnesota Statutes 2018, section 641.15, subdivision 3a, is amended to read:

Subd. 3a. **Intake procedure; approved mental health screening; data sharing.** As part of its intake procedure for new prisoners, the sheriff or local corrections shall use a

mental health screening tool approved by the commissioner of corrections, in consultation with the commissioner of human services and local corrections staff, to identify persons who may have a mental illness. Notwithstanding section 13.85, the sheriff or local corrections may share the names of persons who have screened positive for or may have a mental illness with the local county social services agency. The sheriff or local corrections may refer a person to county personnel of the welfare system, as defined in section 13.46, subdivision 1, paragraph (c), in order to arrange for services upon discharge and may share private data on the individual as necessary to:

(1) provide assistance in filling out an application for medical assistance or MinnesotaCare;

(2) make a referral for case management as provided under section 245.467, subdivision 4;

(3) provide assistance in obtaining a state photo identification;

(4) secure a timely appointment with a psychiatrist or other appropriate community mental health provider;

(5) provide prescriptions for a 30-day supply of all necessary medications; or

(6) provide for behavioral health service coordination.

Sec. 32. Laws 2017, First Special Session chapter 6, article 8, section 71, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 33. Laws 2017, First Special Session chapter 6, article 8, section 72, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for services provided on July 1, 2017, through ~~April 30, 2019, and expires May 1, 2019~~ June 30, 2019, and expires July 1, 2019.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 34. **DIRECTION TO THE COMMISSIONER; SUBSTANCE USE DISORDER TREATMENT PROGRAM SYSTEMS IMPROVEMENT.**

The commissioner of human services, in consultation with counties, tribes, managed care organizations, substance use disorder treatment associations, and other relevant stakeholders, shall develop a plan, proposed timeline, and summary of necessary resources to make systems improvements to minimize the regulatory paperwork for substance use disorder programs licensed under Minnesota Statutes, chapter 245A, and regulated under Minnesota Statutes, chapters 245F and 245G, and Minnesota Rules, parts 2960.0580 to 2960.0700. The plan shall include procedures to ensure that continued input from all stakeholders is considered and that the planned systems improvements maximize client benefits and utility for providers, regulatory agencies, and payers.

Sec. 35. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PERSON-CENTERED TELEPRESENCE PLATFORM EXPANSION.**

(a) By January 15, 2020, the commissioner of human services shall develop and provide to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a proposal, including a timeline, a summary of necessary resources, and any necessary legislative changes, to adapt and expand statewide, a common, interoperable, person-centered telepresence platform for delivering behavioral health and other health care services.

(b) In developing the proposal, the commissioner shall consult with the commissioners of management and budget, MN.IT services, corrections, health, and education, and other relevant stakeholders including but not limited to county services agencies in the areas of human services, health, and corrections or law enforcement from counties outside the metropolitan area; public health representatives; behavioral health and primary care service providers, including providers from outside the metropolitan area; representatives of the Minnesota School Boards Association; representatives of the Minnesota Hospital Association, including rural hospital emergency departments; community mental health centers; adolescent treatment centers; child advocacy centers; and the domestic abuse perpetrator program.

(c) In developing the proposal, the commissioner shall:

(1) explore opportunities for improving behavioral health and other health care service delivery through the use of a common interoperable person-centered telepresence platform that provides connectivity and technical support to potential users;

(2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaboration;

(3) identify necessary standards and capabilities for a common interoperable telepresence platform;

(4) identify barriers to providing telepresence technology, including limited availability of bandwidth, limitations in providing certain services via telepresence, and broadband infrastructure needs;

(5) make recommendations for governance to ensure the person-centered responsiveness of a common telepresence platform;

(6) develop incentives for ongoing innovation by service providers in Minnesota's health and human services systems;

(7) evaluate the use of vendors to provide a common telepresence platform that meets identified standards and capabilities;

(8) identify sustainable financial support for a common telepresence platform, including infrastructure costs and start-up costs for potential users; and

(9) identify the benefits to the state, political subdivisions, tribal governments, and constituents from using a common person-centered telepresence platform for delivering behavioral health services.

Sec. 36. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; IMPROVING SCHOOL-LINKED MENTAL HEALTH GRANT PROGRAM.**

(a) The commissioner of human services, in collaboration with the commissioner of education, representatives from the education community, mental health providers, and advocates, shall assess the school-linked mental health grant program under Minnesota Statutes, section 245.4901, and develop recommendations for improvements. The assessment must include but is not limited to the following:

(1) promoting stability among current grantees and school partners;

(2) assessing the minimum number of full-time equivalents needed per school site to effectively carry out the program;

(3) developing a funding formula that promotes sustainability and consistency across grant cycles;

(4) reviewing current data collection and evaluation; and

(5) analyzing the impact on outcomes when a school has a school-linked mental health program, a multi-tier system of supports, and sufficient school support personnel to meet the needs of students.

(b) The commissioner shall provide a report of the findings of the assessment and recommendations, including any necessary statutory changes, to the legislative committees with jurisdiction over mental health and education by January 15, 2020.

Sec. 37. **OFFICER-INVOLVED COMMUNITY-BASED CARE COORDINATION; PLANNING GRANTS.**

In fiscal year 2020, the commissioner shall award up to ten planning grants of up to $10,000 available to counties and tribes to establish new officer-involved community-based care coordination programs. An eligible applicant for a planning grant under this section is a county or tribe that does not have a fully functioning officer-involved community-based care coordination program and has not yet taken steps to implement an officer-involved community-based care coordination program. Planning grant recipients may use grant funds for the start-up costs of a new officer-involved community-based care coordination program, including data platform design, data collection, and quarterly reporting.

Sec. 38. **COMMUNITY COMPETENCY RESTORATION TASK FORCE.**

Subdivision 1. **Establishment; purpose.** The Community Competency Restoration Task Force is established to evaluate and study community competency restoration programs and develop recommendations to address the needs of individuals deemed incompetent to stand trial.

Subd. 2. **Membership.** (a) The Community Competency Restoration Task Force consists of the following members, appointed as follows:

(1) a representative appointed by the governor's office;

(2) the commissioner of human services or designee;

(3) the commissioner of corrections or designee;

(4) a representative from direct care and treatment services with experience in competency evaluations, appointed by the commissioner of human services;

(5) a representative appointed by the designated State Protection and Advocacy system;

(6) the ombudsman for mental health and developmental disabilities;

(7) a representative appointed by the Minnesota Hospital Association;

(8) a representative appointed by the Association of Minnesota Counties;

(9) two representatives appointed by the Minnesota Association of County Social Service Administrators: one from the seven-county metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2, and one from outside the seven-county metropolitan area;

(10) a representative appointed by the Board of Public Defense;

(11) a representative appointed by the Minnesota County Attorney Association;

(12) a representative appointed by the Chiefs of Police;

(13) a representative appointed by the Minnesota Psychiatric Society;

(14) a representative appointed by the Minnesota Psychological Association;

(15) a representative appointed by the State Court Administrator;

(16) a representative appointed by the Minnesota Association of Community Mental Health Programs;

(17) a representative appointed by the Minnesota Sheriff's Association;

(18) a representative appointed by the Sentencing Commission;

(19) a jail administrator appointed by the commissioner of corrections;

(20) a representative from an organization providing reentry services appointed by the commissioner of corrections;

(21) a representative from a mental health advocacy organization appointed by the commissioner of human services;

(22) a person with direct experience with competency restoration appointed by the commissioner of human services;

(23) representatives from organizations representing racial and ethnic groups overrepresented in the justice system appointed by the commissioner of corrections; and

(24) a crime victim appointed by the commissioner of corrections.

(b) Appointments to the task force must be made no later than July 15, 2019, and members of the task force may be compensated as provided under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 3. **Duties.** The task force must:

(1) identify current services and resources available for individuals in the criminal justice system who have been found incompetent to stand trial;

(2) analyze current trends of competency referrals by county and the impact of any diversion projects or stepping-up initiatives;

(3) analyze selected case reviews and other data to identify risk levels of those individuals, service usage, housing status, and health insurance status prior to being jailed;

(4) research how other states address this issue, including funding and structure of community competency restoration programs, and jail-based programs; and

(5) develop recommendations to address the growing number of individuals deemed incompetent to stand trial including increasing prevention and diversion efforts, providing a timely process for reducing the amount of time individuals remain in the criminal justice system, determining how to provide and fund competency restoration services in the community, and defining the role of the counties and state in providing competency restoration.

Subd. 4. **Officers; meetings.** (a) The commissioner of human services shall convene the first meeting of the task force no later than August 1, 2019.

(b) The task force must elect a chair and vice-chair from among its members and may elect other officers as necessary.

(c) The task force is subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 5. **Staff.** (a) The commissioner of human services must provide staff assistance to support the task force's work.

(b) The task force may utilize the expertise of the Council of State Governments Justice Center.

Subd. 6. **Report required.** (a) By February 1, 2020, the task force shall submit a report on its progress and findings to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

(b) By February 1, 2021, the task force must submit a written report including recommendations to address the growing number of individuals deemed incompetent to stand trial to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health and corrections.

Subd. 7. **Expiration.** The task force expires upon submission of the report in subdivision 6, paragraph (b), or February 1, 2021, whichever is later.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 39. **SPECIALIZED MENTAL HEALTH COMMUNITY SUPERVISION PILOT PROJECT.**

Subdivision 1. **Authorization.** The commissioner of human services shall award a grant to Anoka County to develop and implement a pilot project from July 1, 2019, to June 30, 2021, to evaluate the impact of a coordinated, multidisciplinary service delivery approach for offenders with mental illness who are on probation, parole, supervised release, or pretrial status in Anoka County.

Subd. 2. **Pilot project goals and design.** (a) The pilot project must provide enhanced assessment, case management, treatment services, and community supervision for offenders with mental illness who have symptoms or behavior resulting in heightened risk to harm themselves or others, to recidivate, to commit violations of supervision, or to face incarceration or reincarceration.

(b) The goals of the pilot project are to:

(1) improve mental health service delivery and supervision coordination through establishment of a multidisciplinary caseload management team that must include at least one probation officer and social services professional who share case management responsibilities;

(2) provide expedited assessment, diagnosis, and community-based treatment and programming for acute symptom and behavior management;

(3) enhance community supervision through a specialized caseload and team specifically trained to work with individuals with mental illness;

(4) offer community-based mental health treatment and programming alternatives to incarceration if available and appropriate;

(5) reduce incarceration related to unmanaged mental illness and technical violations;

(6) eliminate or reduce duplication of services between county social services and corrections; and

(7) improve collaboration among, and reduce barriers between, criminal justice system partners, county social services, and community service providers.

Subd. 3. **Target population.** The target population of the pilot project is:

(1) adult offenders on probation, parole, supervised release, or pretrial status in Anoka County who have been assessed with significant or unmanaged mental illness or acute symptoms that pose a risk to harm themselves or others, or increase their risk to recidivate or commit technical violations of supervision;

(2) adult offenders who receive county social service case management for mental illness while under correctional supervision in Anoka County; and

(3) adult offenders incarcerated in jail in Anoka County who have significant or unmanaged mental illness and may be safely treated in a community setting under correctional supervision.

Subd. 4. **Evaluation and report.** By October 1, 2021, Anoka County must report to the commissioner of human services on the impact and outcomes of the project.

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2018, section 254B.03, subdivision 4a, is repealed.

(b) Minnesota Rules, parts 9530.6800; and 9530.6810, are repealed.

ARTICLE 4
CONTINUING CARE FOR OLDER ADULTS

Section 1. Minnesota Statutes 2018, section 144A.073, is amended by adding a subdivision to read:

Subd. 16. **Moratorium exception funding.** In fiscal year 2020, the commissioner may approve moratorium exception projects under this section for which the full annualized state share of medical assistance costs does not exceed $2,000,000 plus any carryover of previous appropriations for this purpose.

Sec. 2. Minnesota Statutes 2018, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to ~~(n)~~ (o).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under

section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

(h) The portion related to single-bed room incentives is as determined under section 256R.41.

(i) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the actual amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(j) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(k) The portion related to the Public Employees Retirement Association is actual costs divided by the sum of the facility's resident days.

(l) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(m) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(n) The portion related to special dietary needs is the amount determined under section 256R.51.

(o) The portion related to the rate adjustments for border city facilities is the amount determined under section 256R.481.

Sec. 3. **[256R.481] RATE ADJUSTMENTS FOR BORDER CITY FACILITIES.**

(a)The commissioner shall allow each nonprofit nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed costs payment rate.

(b) A facility seeking an add-on to its external fixed costs payment rate under this section must apply annually to the commissioner to receive the add-on. A facility must submit the application within 60 calendar days of the effective date of any add-on under this section. The commissioner may waive the deadlines required by this paragraph under extraordinary circumstances.

(c) The commissioner shall provide the add-on to each eligible facility that applies by the application deadline.

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1 as determined under section 256R.22, subdivision 4.

EFFECTIVE DATE. The add-on to the external fixed costs payment rate described in Minnesota Statutes, section 256R.481, is available for the rate years beginning on and after January 1, 2021.

Sec. 4. **REPEALER.**

Minnesota Statutes 2018, section 256R.53, subdivision 2, is repealed effective January 1, 2021.

ARTICLE 5
DISABILITY SERVICES

Section 1. Minnesota Statutes 2018, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section

245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care;

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services;

(6) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service to help the person make an informed choice; and

(ii) the person's foster care services are less than or equal to the cost of the person's services delivered in the residential care waiver service setting as determined by the lead agency; or

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, ~~2018~~ 2019. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency; or

(8) a vacancy in a setting granted an exception under clause (7), created between January 1, 2017, and the date of the exception request, by the departure of a person receiving services under chapter 245D and residing in the unlicensed setting between January 1, 2017, and May 1, 2017. This exception is available when the lead agency provides documentation to the commissioner on the eligibility criteria being met. This exception is available until June 30, 2019.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident ~~served by the program moves out of a~~ for any reason permanently vacates a bed in an adult foster care home that is not the primary residence of the license holder ~~according to section 256B.49, subdivision 15, paragraph (f)~~, or ~~the~~ a bed in an adult community residential setting, the county shall immediately inform the ~~Department of Human Services Licensing Division~~ commissioner. Within six months of the second bed being permanently vacated, the ~~department may~~ commissioner shall decrease

the statewide licensed capacity for adult foster care settings by one bed for every two beds vacated.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process

identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

EFFECTIVE DATE. This section is effective July 1, 2019, except the amendment to paragraph (a) adding clause (8) is effective retroactively from July 1, 2018, and applies to exception requests made on or after that date.

Sec. 2. Minnesota Statutes 2018, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of ~~five~~ up to six beds, including roomers and boarders, according to paragraphs (b) to (g).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to five, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to five, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of ~~five~~ six adults if the fifth ~~bed does~~ and sixth beds do not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed or six-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity of five or six adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 3. Minnesota Statutes 2018, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that

are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental ~~disability~~ disabilities, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental ~~disability~~ disabilities waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental ~~disability~~ disabilities waiver plans;

(5) night supervision services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver ~~plan~~ plans;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental ~~disability~~ disabilities, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; and

(7) individual community living support under section 256B.0915, subdivision 3j.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) ~~behavioral~~ positive support services as defined under the brain injury and community access for disability inclusion, community alternative care, and developmental disabilities waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans; and

(iii) specialist services as defined under the current brain injury, community access for disability inclusion, community alternative care, and developmental ~~disability~~ disabilities waiver ~~plan~~ plans;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental ~~disability~~ disabilities waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental ~~disability~~ disabilities waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental ~~disability~~ disabilities waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans; and

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental ~~disability~~ disabilities waiver plans.

Sec. 4. Minnesota Statutes 2018, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per year, or within 30 days of a written request by the person, the person's legal representative, or the case manager, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum ~~or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year~~. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager to discuss how technology might be used to meet the person's desired outcomes. The coordinated service and support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision made related to the use of technology and a description of any further research that must be completed before a decision regarding the use of technology can be made. Nothing in this paragraph

requires the coordinated service and support plan addendum to include the use of technology for the provision of services.

~~(b)~~ (c) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a report available at the time of the progress review meeting. The report must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the mailing of the coordinated service and support plan addendum, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 5. Minnesota Statutes 2018, section 245D.09, subdivision 5, is amended to read:

Subd. 5. **Annual training.** A license holder must provide annual training to direct support staff on the topics identified in subdivision 4, clauses (3) to (10). If the direct support staff has a first aid certification, annual training under subdivision 4, clause (9), is not required as long as the certification remains current. ~~A license holder must provide a minimum of 24 hours of annual training to direct service staff providing intensive services and having fewer than five years of documented experience and 12 hours of annual training to direct service staff providing intensive services and having five or more years of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a) to (f). Training on relevant topics received from sources other than the license holder may count toward training requirements. A license holder must provide a minimum of 12 hours of annual training to~~

~~direct service staff providing basic services and having fewer than five years of documented experience and six hours of annual training to direct service staff providing basic services and having five or more years of documented experience.~~

Sec. 6. Minnesota Statutes 2018, section 245D.09, subdivision 5a, is amended to read:

Subd. 5a. **Alternative sources of training.** ~~The commissioner may approve online training and competency-based assessments in place of a specific number of hours of training in the topics covered in subdivision 4. The commissioner must provide a list of preapproved trainings that do not need approval for each individual license holder.~~

Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from other sources and of each staff person's competency in the required area according to the requirements in subdivision 3.

Sec. 7. Minnesota Statutes 2018, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **~~Behavior~~ Positive support professional qualifications.** A ~~behavior~~ positive support professional providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); ~~or~~

(vi) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services; or

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 8. Minnesota Statutes 2018, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **~~Behavior~~ Positive support analyst qualifications.** (a) A ~~behavior~~ positive support analyst providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the

following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; ~~or~~

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17; or

(3) be a board-certified behavior analyst or board-certified assistant behavior analyst by the Behavior Analyst Certification Board, Incorporated.

(b) In addition, a ~~behavior~~ positive support analyst must:

(1) have four years of supervised experience ~~working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~ conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

(2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~ training prior to hire or within 90 calendar days of hire that includes:

(i) ten hours of instruction in functional assessment and functional analysis;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavior support strategies;

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

(v) eight hours of instruction on principles of person-centered thinking;

~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

~~(4) have received ten hours of instruction on design of positive practices behavior support strategies;~~

~~(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;~~

~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive support; and

~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

Sec. 9. Minnesota Statutes 2018, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive support specialist providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans or successor plans:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received training prior to hire or within 90 calendar days of hire that includes:

(i) a minimum of four hours of training in functional assessment;

~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of behavior;

~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral support strategies; and

(iv) eight hours of instruction on principles of person-centered thinking;

~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives ~~behavioral~~ positive support; and

~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

Sec. 10. Minnesota Statutes 2018, section 252.275, subdivision 3, is amended to read:

Subd. 3. **Reimbursement.** Counties shall be reimbursed for all expenditures made pursuant to subdivision 1 at a rate of ~~70~~ 85 percent, up to the allocation determined pursuant to subdivisions 4 and 4b. However, the commissioner shall not reimburse costs of services for any person if the costs exceed the state share of the average medical assistance costs for services provided by intermediate care facilities for a person with a developmental disability for the same fiscal year, and shall not reimburse costs of a onetime living allowance for any person if the costs exceed $1,500 in a state fiscal year. The commissioner may make payments to each county in quarterly installments. The commissioner may certify an advance of up to 25 percent of the allocation. Subsequent payments shall be made on a reimbursement basis for reported expenditures and may be adjusted for anticipated spending patterns.

Sec. 11. **[256.488] ADAPTIVE FITNESS ACCESS GRANT.**

Subdivision 1. **Definitions.** (a) "Adaptive fitness" means the practice of physical fitness by an individual with primary physical disabilities, either as a consequence of the natural aging process or due to a developmental disability, mental health issue, congenital condition, trauma, injury, or disease.

(b) "Adaptive fitness center" means a center with modified equipment, equipment arrangement and space for access, and trainers with skills in modifying exercise programs specific to the physical and cognitive needs of individuals with disabilities.

(c) "Commissioner" means the commissioner of human services.

(d) "Disability" has the meaning given in the Americans with Disabilities Act.

Subd. 2. **Establishment.** A statewide adaptive fitness access grant program is established under the Department of Human Services to award grants to promote access to adaptive fitness for individuals with disabilities.

Subd. 3. **Application and review.** (a) The commissioner must develop a grant application that must contain, at a minimum:

(1) a description of the purpose or project for which the grant will be used;

(2) a description of the specific problem the grant intends to address;

(3) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant;

(4) a description of the existing frameworks and experience providing adaptive fitness; and

(5) a proposed process for documenting and evaluating results of the grant.

(b) An applicant must apply using the grant application developed by the commissioner.

(c) The commissioner shall review each application. The commissioner shall establish criteria to evaluate applications, including but not limited to:

(1) the application is complete;

(2) the eligibility of the applicant;

(3) the thoroughness and clarity in identifying the specific problem the grant intends to address;

(4) a description of the population demographics and service area of the proposed project;

(5) documentation the grant applicant has received cash or in-kind contributions of value equal to the requested grant amount; and

(6) the proposed project's longevity and demonstrated financial sustainability after the initial grant period.

(d) In evaluating applications, the commissioner may request additional information regarding a proposed project, including information on project cost. An applicant's failure to timely provide the information requested disqualifies an applicant.

Subd. 4. **Awards.** (a) The commissioner shall award grants to eligible applicants to provide adaptive fitness for individuals with disabilities.

(b) The commissioner shall award grants to qualifying nonprofit organizations that provide adaptive fitness in adaptive fitness centers. Grants must be used to assist one or more qualified nonprofit organizations to provide adaptive fitness, including: (1) stay fit; (2) activity-based locomotor exercise; (3) equipment necessary for adaptive fitness programs; (4) operating expenses related to staffing of adaptive fitness programs; and (5) other adaptive fitness programs as deemed appropriate by the commissioner.

(c) An applicant may apply for and the commissioner may award grants for two-year periods, and the commissioner shall determine the number of grants awarded. The commissioner may reallocate underspending among grantees within the same grant period.

Subd. 5. **Report.** Beginning December 1, 2020, and every two years thereafter, the commissioner of human services shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services. The report shall, at a minimum, include the amount of funding awarded for each project, a description of the programs and services funded, plans for the long-term sustainability of the projects, and data on outcomes for the programs and services funded. Grantees must provide information and data requested by the commissioner to support the development of this report.

Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, ~~2010~~ 2020, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one critical activity of daily living as defined in section 256B.0659, subdivision 1, paragraph ~~(b)~~ (e), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c), or have a behavior that shows increased vulnerability due to cognitive deficits or socially inappropriate behavior that requires assistance at least four times per week. Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0654. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0654. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient

as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner shall implement the modified eligibility criteria as annual assessments occur. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 13. Minnesota Statutes 2018, section 256B.0652, subdivision 6, is amended to read:

Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in subdivision 11 and section 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for recipients with dependencies in two or more activities of daily living:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) presence of complex health-related needs as defined in section 256B.0659; and

(3) presence of Level I behavior as defined in section 256B.0659.

(c) For purposes meeting the criteria in paragraph (b), the methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the

personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659, subdivision 4, paragraph (d).

(d) Effective July 1, 2011, the home care rating for recipients who have a dependency in one activity of daily living or Level I behavior shall equal no more than two units per day. Effective January 1, 2020, the home care rating for recipients who have a dependency in one critical activity of daily living or one Level I behavior or that require assistance with a behavior that shows increased vulnerability due to cognitive deficits or socially inappropriate behavior at least four times per week shall equal no more than two units per day. Recipients with this home care rating are not subject to the methodology in paragraph (c) and are not eligible for more than two units per day.

(e) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner shall implement the modified eligibility criteria as annual assessments occur. The commissioner shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2018, section 256B.0658, is amended to read:

256B.0658 HOUSING ACCESS GRANTS.

The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals ~~eligible for publicly funded home and community-based services, including state plan home care~~ with a disability as defined in section 256B.051, subdivision 2, paragraph (e), to access housing. Grants may be awarded to agencies that may include, but are not limited to, the following supports: assessment to ensure suitability of housing, accompanying an individual to look at housing, filling out applications and rental agreements, meeting with landlords, helping with Section

8 or other program applications, helping to develop a budget, obtaining furniture and household goods, if necessary, and assisting with any problems that may arise with housing.

Sec. 15. Minnesota Statutes 2018, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Sec. 16. Minnesota Statutes 2018, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance

with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care assistance services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides services, according to the care plan in subdivision 7, to a recipient who qualifies for ten or more hours per day of personal care assistance services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state-approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 17. Minnesota Statutes 2018, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 110 percent of the rate paid for personal care assistance services shall be paid for services provided to persons who qualify for ten or more hours of personal care assistance service per day when provided by a personal care assistant who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for personal care assistance services includes, and is not in addition to, any rate adjustments implemented by the commissioner to comply with the terms of a collective bargaining

agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 for increased financial incentives for providing services to people with complex needs.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for provider enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment, reenrollment, and revalidation as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If the Medicaid revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced personal care assistance services are provided and submitted for an enhanced rate under subdivision 17a;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect

the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

Subd. 24. **Personal care assistance provider agency; general duties.** A personal care assistance provider agency shall:

(1) enroll as a Medicaid provider meeting all provider standards, including completion of the required provider training;

(2) comply with general medical assistance coverage requirements;

(3) demonstrate compliance with law and policies of the personal care assistance program to be determined by the commissioner;

(4) comply with background study requirements;

(5) verify and keep records of hours worked by the personal care assistant and qualified professional;

(6) not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential recipients, guardians, or family members;

(7) pay the personal care assistant and qualified professional based on actual hours of services provided;

(8) withhold and pay all applicable federal and state taxes;

(9) ~~effective January 1, 2010,~~ document that the agency uses a minimum of 72.5 percent of the revenue generated by the medical assistance rate for personal care assistance services for employee personal care assistant wages and benefits. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation;

(10) make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

(11) enter into a written agreement under subdivision 20 before services are provided;

(12) report suspected neglect and abuse to the common entry point according to section 256B.0651;

(13) provide the recipient with a copy of the home care bill of rights at start of service; ~~and~~

(14) request reassessments at least 60 days prior to the end of the current authorization for personal care assistance services, on forms provided by the commissioner~~.~~; and

(15) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d).

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), for any services billed at the enhanced rate under subdivision 17a;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; and

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment

can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for state plan ~~home care~~ services identified in:

(i) section 256B.0625, subdivisions ~~7,~~ 19a~~,~~ and 19c;

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, ~~determination of eligibility for~~ gaining access to case management services available under sections 256B.0621, subdivision 2, ~~paragraph~~ clause (4), ~~and~~ 256B.0924, and Minnesota Rules, part 9525.0016;

(3) determination ~~of institutional level of care, home and community-based service waiver, and other service~~ of eligibility ~~as required under section 256B.092, determination of eligibility for family support grants under section 252.32,~~ for semi-independent living services under section 252.275~~, and day training and habilitation services under section 256B.092~~; and

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3).

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this section, "informed choice" means a voluntary choice of services by a person from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person to empower the person to make decisions.

Sec. 22. Minnesota Statutes 2018, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services ~~and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement~~. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face conversational interview with the person being assessed ~~and~~. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of

service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs ~~prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment~~ the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by the commissioner, regardless of whether the ~~individual~~ person is eligible for Minnesota health care programs.

(f) For a person being assessed for elderly waiver services under section 256B.0915, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers, including service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(j) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and

screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated.

(k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

Sec. 23. Minnesota Statutes 2018, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a face-to-face reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments ~~allow for~~ require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments verify continued eligibility or offer alternatives as warranted and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments~~ reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 24. Minnesota Statutes 2018, section 256B.0911, is amended by adding a subdivision to read:

Subd. 3g. **Assessments for Rule 185 case management.** Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must instead develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually for persons with developmental disabilities who are receiving only case management services under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an assessment under this section.

Sec. 25. Minnesota Statutes 2018, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 26. Minnesota Statutes 2018, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 27. Minnesota Statutes 2018, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions 6b and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h, and the rate adjustment under subdivision 18. Medical assistance rates paid to

customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h, plus any rate adjustment under subdivision 18.

Sec. 28. Minnesota Statutes 2018, section 256B.0915, is amended by adding a subdivision to read:

Subd. 18. **Disproportionate share establishment customized living rate adjustment.** (a) For purposes of this section, "designated disproportionate share establishment" means a housing with services establishment registered under chapter 144D that meets the requirements of paragraph (d).

(b) A housing with services establishment registered under chapter 144D may apply annually between June 1 and June 15 to the commissioner to be designated as a disproportionate share establishment. The applying housing with services establishment must apply to the commissioner in the manner determined by the commissioner. The applying housing with services establishment must document as a percentage the census of elderly waiver participants residing in the establishment on May 31 of the year of application.

(c) Only a housing with services establishment registered under chapter 144D with a census of at least 50 percent elderly waiver participants on May 31 of the application year is eligible under this section for designation as a disproportionate share establishment.

(d) By June 30, the commissioner shall designate as a disproportionate share establishment any housing with services establishment that complies with the requirements of paragraph (b) and meets the eligibility criteria described in paragraph (c).

(e) A designated disproportionate share establishment's customized living rate adjustment is the sum of 0.83 plus the product of 0.36 multiplied by the percentage of elderly waiver participants residing in the establishment as reported on the establishment's most recent application for designation as a disproportionate share establishment. No establishment may receive a customized living rate adjustment greater than 1.10.

(f) The commissioner shall multiply the customized living rate and 24-hour customized living rate for a designated disproportionate share establishment by the amount determined under paragraph (e).

(g) The value of the rate adjustment under paragraph (e) shall not be included in an individual elderly waiver client's monthly case mix budget cap.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later, and applies to rates paid on or after January 1, 2021. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 29. Minnesota Statutes 2018, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 30. Minnesota Statutes 2018, section 256B.092, is amended by adding a subdivision to read:

Subd. 12a. **Developmental disabilities waiver growth limit.** The commissioner shall limit the total number of people receiving developmental disabilities waiver services to the number of people receiving developmental disabilities waiver services on June 30, 2019. The commissioner shall only add new recipients when an existing recipient permanently leaves the program. The commissioner shall reserve capacity, within enrollment limits, to re-enroll persons who temporarily discontinue and then resume waiver services within 90 days of the date that services were discontinued. When adding a new recipient, the commissioner shall target persons who meet the priorities for accessing waiver services identified in subdivision 12. The allocation limits include conversions from intermediate care facilities for persons with developmental disabilities unless capacity at the facility is permanently converted to home and community-based services through the developmental disabilities waiver.

Sec. 31. Minnesota Statutes 2018, section 256B.0921, is amended to read:

256B.0921 HOME AND COMMUNITY-BASED SERVICES ~~INCENTIVE~~ INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

Sec. 32. Minnesota Statutes 2018, section 256B.49, is amended by adding a subdivision to read:

Subd. 11b. **Community access for disability inclusion waiver growth limit.** The commissioner shall limit the total number of people receiving community access for disability inclusion waiver services to the number of people receiving community access for disability inclusion waiver services on June 30, 2019. The commissioner shall only add new recipients when an existing recipient permanently leaves the program. The commissioner shall reserve capacity, within enrollment limits, to re-enroll persons who temporarily discontinue and then resume waiver services within 90 days of the date that services were discontinued. When adding a new recipient, the commissioner shall target individuals who meet the priorities for accessing waiver services identified in subdivision 11a. The allocation limits includes conversions and diversions from nursing facilities.

Sec. 33. Minnesota Statutes 2018, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the written coordinated service and support plan within ~~ten working days after the case manager receives the plan from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 60 calendar days from the assessment visit;

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers, including services provided in a non-disability-specific setting;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

Sec. 34. Minnesota Statutes 2018, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b. The certified assessor, with the permission of the recipient or the recipient's designated legal representative, may invite other individuals to attend the assessment. With the permission of the recipient or the recipient's designated legal representative, the recipient's current provider of services may submit a written report outlining their recommendations regarding the recipient's care needs prepared by a direct service employee ~~with at least 20 hours of service to that client. The certified assessor must notify the provider of the date by which this information is to be submitted. This information shall be provided to the certified assessor and the person or the person's legal representative and must be considered prior to the finalization of the assessment or reassessment~~ who is familiar with the person. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

(d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 35. Minnesota Statutes 2018, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Direct care staff" means employees providing direct services to an individual receiving services under this section. Direct care staff excludes executive, managerial, or administrative staff.

~~(e)~~ (f) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (k) "Rates management system" means a web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph (f), providing or available to provide more than one individual with direct support and

assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (o) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for prevocational services, a unit of service is a day or ~~an hour~~ 15 minutes. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 36. Minnesota Statutes 2018, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

~~(6)~~ (5) customized living;

~~(7)~~ (6) day training and habilitation;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

~~(8)~~ (10) housing access coordination;

~~(9)~~ (11) independent living skills;

(12) independent living skills specialist services;

(13) individualized home supports;

~~(10)~~ (14) in-home family support;

~~(11)~~ (15) night supervision;

~~(12)~~ (16) personal support;

(17) positive support service;

~~(13)~~ (18) prevocational services;

~~(14)~~ (19) residential care services;

~~(15)~~ (20) residential support services;

~~(16)~~ (21) respite services;

~~(17)~~ (22) structured day services;

~~(18)~~ (23) supported employment services;

~~(19)~~ (24) supported living services;

~~(20)~~ (25) transportation services; and

~~(21) individualized home supports;~~

~~(22) independent living skills specialist services;~~

~~(23) employment exploration services;~~

~~(24) employment development services;~~

~~(25) employment support services; and~~

(26) other services as approved by the federal government in the state home and community-based services plan.

Sec. 37. Minnesota Statutes 2018, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code

31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) The commissioner shall adjust the base wage index in paragraph (j) with a competitive workforce factor of 4.7 percent to provide increased compensation to direct care staff. A provider shall use the additional revenue from the competitive workforce factor to increase wages for or to improve benefits provided to direct care staff.

(c) Beginning February 1, 2021, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor. The report shall include recommendations to adjust the competitive workforce factor using (1) the most recently available wage data by SOC code of the weighted average wage for direct care staff for residential services and direct care staff for day services; (2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and (3) labor market data as required under subdivision 10a, paragraph (g). The commissioner shall not recommend in any biennial report an increase or decrease of the competitive workforce factor by more than two percentage points from the current value. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.

~~(b)~~ (d) Component values for residential support services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

~~(c)~~ (e) Component values for family foster care are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

~~(d)~~ (f) Component values for day services for all services are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 9.4 percent.

~~(e)~~ (g) Component values for unit-based services with programming are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan supports ratio: 15.5 percent;

(5) client programming and supports ratio: 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

~~(f)~~ (h) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) program plan support ratio: 7.0 percent;

(5) client programming and support ratio: 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 2.9 percent; and

(8) absence and utilization factor ratio: 3.9 percent.

~~(g)~~ (i) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio: 11 percent;

(2) employee vacation, sick, and training allowance ratio: 8.71 percent;

(3) employee-related cost ratio: 23.6 percent;

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 2.9 percent; and

(6) absence and utilization factor ratio: 3.9 percent.

~~(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system.~~ (j) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the base wage index in paragraph (a) based on ~~the most recently available~~ wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

~~(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system.~~ (k) On July 1, 2022, and every ~~five~~ two years thereafter, the commissioner shall update the framework components in paragraph ~~(d)~~ (f), clause (5); paragraph ~~(e)~~ (g), clause (5); ~~and~~ paragraph ~~(f)~~ (h), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the

~~date of the~~ data ~~most recently~~ available 30 months and one day prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(l) Upon the implementation of automatic inflation adjustments under paragraphs (j) and (k), rate adjustments authorized under section 256B.439, subdivision 7; Laws 2013, chapter 108, article 7, section 60; and Laws 2014, chapter 312, article 27, section 75, shall be removed from service rates calculated under this section.

(m) Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of automatic inflation adjustments under paragraphs (j) and (k).

~~(j)~~ (n) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(o) The commissioner shall update the general administrative support ratio in paragraph (d), clause (4); paragraph (e), clause (4); paragraph (f), clause (6); paragraph (g), clause (6); paragraph (h), clause (6); and paragraph (i), clause (4), for any changes to the annual licensing fee under section 245A.10, subdivision 4, paragraph (b). The commissioner shall adjust these ratios higher or lower by an amount equal in value to the percent change in general administrative support costs attributable to the change in the licensing fee. The commissioner shall publish these updated ratios and load them into the rate management system.

EFFECTIVE DATE. This section is effective January 1, 2021, or upon federal approval, whichever is later, except the new paragraphs (b) and (o) are effective January 1, 2020, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2018, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of shared staffing and individual direct staff hours to meet a recipient's needs provided on site or through monitoring technology;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct-care rate;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of shared and individual direct staff hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(b)~~ (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), excluding any shared and individual direct staff hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(b)~~ (d), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staff hours provided through monitoring technology, by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(b)~~ (d), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport, based on the resident with the highest assessed need.

(b) The total rate must be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared and individual direct staff hours provided through monitoring technology that was excluded in clause (7);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio;

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount; and

(4) adjust the result of clause (3) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The payment methodology for customized living, 24-hour customized living, and residential care services must be the customized living tool. Revisions to the customized living tool must be made to reflect the services and activities unique to disability-related recipient needs.

(d) For individuals enrolled prior to January 1, 2014, the days of service authorized must meet or exceed the days of service used to convert service agreements in effect on December 1, 2013, and must not result in a reduction in spending or service utilization due to conversion during the implementation period under section 256B.4913, subdivision 4a. If during the implementation period, an individual's historical rate, including adjustments required under section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate determined in this subdivision, the number of days authorized for the individual is 365.

(e) The number of days authorized for all individuals enrolling after January 1, 2014, in residential services must include every day that services start and end.

Sec. 39. Minnesota Statutes 2018, section 256B.4914, subdivision 7, is amended to read:

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service and staffing ratio to meet a recipient's needs:

(i) the staffing ratios for the units of service provided to a recipient in a typical week must be averaged to determine an individual's staffing ratio; and

(ii) the commissioner, in consultation with service providers, shall develop a uniform staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of day program direct staff hours and nursing hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of day direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(d)~~ (f), clause (5);

(10) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15 minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services;

(16) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(17) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

Sec. 40. Minnesota Statutes 2018, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, independent living skills specialist services, individualized home supports, hourly supported living services, employment exploration services, employment development services, supported employment, and employment support services provided to an individual outside of any day or residential service plan must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct-care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph ~~(e)~~ (g), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for supported employment provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed three. For employment support services provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed six. For independent living skills training and individualized home supports provided in a shared manner, divide the total payment amount in clause (12) by the number of service recipients, not to exceed two; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 41. Minnesota Statutes 2018, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming, including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential

service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(6) combine the results of clauses (4) and (5), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph ~~(f)~~ (h), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of day units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (21);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph ~~(g)~~ (i), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 42. Minnesota Statutes 2018, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** ~~(a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.~~

~~(b)~~ (a) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

~~(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.~~

~~(d)~~ (b) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions ~~6~~ 5 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

(2) values for services where monitoring technology replaces staff time;

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) direct care workforce labor market measures;

(9) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; ~~and~~

~~(9)~~ (10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section~~.~~; and

(11) different competitive workforce factors by service.

~~(e)~~ (c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs ~~(b) to (d)~~ (a) and (b) on ~~the following dates:~~

~~(1) January 15, 2015, with preliminary results and data;~~

~~(2) January 15, 2016, with a status implementation update, and additional data and summary information;~~

~~(3) January 15, 2017, with the full report; and~~

~~(4)~~ January 15, ~~2020~~ 2021, with another full report, and a full report once every four years thereafter.

~~(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015.~~ (d) Beginning ~~July 1, 2017~~ January 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors ~~when adjustments required under subdivision 5, paragraph (h), occur~~ once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

~~(g)~~ (e) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

~~(h)~~ (f) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014, or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

~~(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.~~

~~(j)~~ (g) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

(h) The commissioner, in consultation with stakeholders, shall study value-based models and outcome-based payment strategies for fee-for-service home and community-based services and report to the legislative committees with jurisdiction over the disability waiver rate system by October 1, 2020, with recommended strategies to improve the quality, efficiency, and effectiveness of services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 43. Minnesota Statutes 2018, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, ~~2020~~ 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph ~~(e)~~ (c). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) By December 31, 2020, providers paid with rates calculated under subdivision 5, paragraph (b), shall identify additional revenues from the competitive workforce factor and prepare a written distribution plan for the revenues. A provider shall make the provider's distribution plan available and accessible to all direct care staff for a minimum of one calendar year. Upon request, a provider shall submit the written distribution plan to the commissioner.

(g) Providers enrolled to provide services with rates determined under section 256B.4914, subdivision 3, shall submit labor market data to the commissioner annually on or before November 1, including but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) overtime wages of direct care staff;

(4) hours worked by direct care staff;

(5) overtime hours worked by direct care staff;

(6) benefits provided to direct care staff;

(7) direct care staff job vacancies; and

(8) direct care staff retention rates.

(h) The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data obtained under paragraph (g).

(i) The commissioner shall temporarily suspend payments to the provider if data requested under paragraph (g) is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment except paragraph (g) is effective November 1, 2019, and paragraph (h) is effective February 1, 2020.

Sec. 44. Minnesota Statutes 2018, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services has the authority to manage statewide licensed corporate foster care or community residential settings capacity, including the reduction and realignment of licensed capacity of a current foster care or community residential setting to accomplish the consolidation or closure of settings. The commissioner shall implement a program for planned closure of licensed corporate adult foster care or community residential settings, necessary as a preferred method to: (1) respond to the informed decisions of those individuals who want to move out of these settings into other types of community settings; and (2) achieve ~~necessary budgetary savings~~ the reduction of statewide licensed capacity required in section 245A.03, subdivision 7, paragraphs (c) and (d). Closure determinations by the commissioner are final and not subject to appeal.

Sec. 45. Minnesota Statutes 2018, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **Variable rate adjustments.** (a) ~~For rate years beginning on or after October 1, 2000,~~ When there is a documented increase in the needs of a current ICF/DD recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. Variable rate adjustments made under this subdivision replace payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a. ~~Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1).~~ Once approved, variable rate adjustments must continue to remain in place unless there is an identified change in need. A review of needed resources must be done at the time of the individual's annual support plan meeting. A request to adjust the resources of the individual must be submitted if any change in need is identified. Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) The county of financial responsibility must act on a variable rate request within 30 days and notify the initiator of the request of the county's recommendation in writing.

~~(b)~~ (c) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming which is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; ~~or~~

(4) a demonstrated behavioral or cognitive need that significantly impacts the type or amount of services needed by the individual~~.~~; or

~~(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.~~

~~(d) The facility shall provide an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.~~

~~(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.~~

(5) a demonstrated increased need for staff assistance, changes in the type of staff credentials needed, or a need for expert consultation based on assessments conducted prior to the annual support plan meeting.

(d) Variable rate requests must include the following information:

(1) the service needs change;

(2) the variable rate requested and the difference from the current rate;

(3) a basis for the underlying costs used for the variable rate and any accompanying documentation; and

(4) documentation of the expected outcomes to be achieved and the frequency of progress monitoring associated with the rate increase.

EFFECTIVE DATE. This section is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 46. Minnesota Statutes 2018, section 256B.5013, subdivision 6, is amended to read:

Subd. 6. **Commissioner's responsibilities.** The commissioner shall:

(1) make a determination to approve, deny, or modify a request for a variable rate adjustment within 30 days of the receipt of the completed application;

(2) notify the ICF/DD facility and county case manager of the ~~duration and conditions of variable rate adjustment approvals~~ determination; and

(3) modify MMIS II service agreements to reimburse ICF/DD facilities for approved variable rates.

Sec. 47. Minnesota Statutes 2018, section 256B.5015, subdivision 2, is amended to read:

Subd. 2. **Services during the day.** (a) Services during the day, as defined in section 256B.501, but excluding day training and habilitation services, shall be paid as a pass-through payment ~~no later than January 1, 2004~~. The commissioner shall establish rates for these services, other than day training and habilitation services, at ~~levels that do not exceed 75~~ 100 percent of a recipient's day training and habilitation service costs prior to the service change.

(b) An individual qualifies for services during the day under paragraph (a) if:

(1) through consultation with the individual and their support team or interdisciplinary team, it has been determined that the individual's needs can best be met through partial or full retirement from:

(i) participation in a day training and habilitation service; or

(ii) the use of services during the day in the individual's home environment; and

(2) in consultation with the individual and their support team or interdisciplinary team, an individualized plan has been developed with designated outcomes that:

(i) addresses the support needs and desires contained in the person-centered plan or individual support plan; and

(ii) includes goals that focus on community integration as appropriate for the individual.

(c) When establishing a rate for these services, the commissioner shall also consider an individual recipient's needs as identified in the ~~individualized service~~ individual support plan and the person's need for active treatment as defined under federal regulations. The pass-through payments for services during the day shall be paid separately by the commissioner and shall not be included in the computation of the ICF/DD facility total payment rate.

Sec. 48. Minnesota Statutes 2018, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a participant in the alternative care program under section 256B.0913;

(3) is a waiver participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a person's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) based on an assessment under section 256B.0911, require assistance and be determined dependent in one critical activity of daily living or one Level I behavior ~~based on assessment under section 256B.0911~~ or have a behavior that shows increased vulnerability due to cognitive deficits or socially inappropriate behavior that requires assistance at least four times per week; and

(2) is not a participant under a family support grant under section 252.32.

(c) A pregnant woman eligible for medical assistance under section 256B.055, subdivision 6, is eligible for CFSS without federal financial participation if the woman: (1) is eligible for CFSS under paragraphs (a) and (b); and (2) does not meet institutional level of care, as determined under section 256B.0911.

Sec. 49. Minnesota Statutes 2018, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service authorization amount.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a participant:

(1) the total number of dependencies of activities of daily living;

(2) the presence of complex health-related needs; and

(3) the presence of Level I behavior.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters ~~P~~ LT through Z and EN and has the following base number of service units assigned:

(1) ~~P~~ LT home care rating requires ~~Level I behavior or one to three dependencies in ADLs and qualifies the person for five service units~~ the presence of increased vulnerability due to cognitive deficits and socially inappropriate behavior that requires assistance at least four times per week, the presence of a Level I behavior, or a dependency in one critical activity of daily living, and qualifies the person for two service units;

(2) P home care rating requires two to three dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for five services units;

(3) Q home care rating requires Level I behavior and ~~one~~ two to three dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for six service units;

~~(3)~~ (4) R home care rating requires a complex health-related need and ~~one~~ two to three dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for seven service units;

~~(4)~~ (5) S home care rating requires four to six dependencies in ADLs, one of which must be a critical ADL, and qualifies the person for ten service units;

~~(5)~~ (6) T home care rating requires Level I behavior and four to six dependencies in ADLs ~~and Level I behavior~~, one of which must be a critical ADL, and qualifies the person for 11 service units;

~~(6)~~ (7) U home care rating requires four to six dependencies in ADLs, one of which must be a critical ADL, and a complex health-related need and qualifies the person for 14 service units;

~~(7)~~ (8) V home care rating requires seven to eight dependencies in ADLs and qualifies the person for 17 service units;

~~(8)~~ (9) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies the person for 20 service units;

~~(9)~~ (10) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies the person for 30 service units; and

~~(10)~~ (11) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). A person who meets the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and home care nursing services is limited to a total of 96 service units per day for those services

in combination. Additional units may be authorized when a person's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living;

(2) 30 additional minutes per day for each complex health-related need; and

(3) 30 additional minutes per day when the behavior requires assistance at least four times per week for one or more of the following behaviors:

(i) level I behavior;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for participants who are verbally aggressive or resistive to care so that the time needed to perform activities of daily living is increased.

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Sec. 50. Minnesota Statutes 2018, section 256C.23, is amended by adding a subdivision to read:

Subd. 7. **Family and community intervener.** "Family and community intervener" means a paraprofessional, specifically trained in deafblindness, who works one-on-one with a child who is deafblind to provide critical connections to people and the environment.

Sec. 51. Minnesota Statutes 2018, section 256C.261, is amended to read:

256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND.

(a) The commissioner of human services shall use at least 35 percent of the deafblind services biennial base level grant funding for services and other supports for a child who is deafblind and the child's family. The commissioner shall use at least 25 percent of the deafblind services biennial base level grant funding for services and other supports for an adult who is deafblind.

The commissioner shall award grants for the purposes of:

(1) providing services and supports to persons who are deafblind; and

(2) developing and providing training to counties and the network of senior citizen service providers. The purpose of the training grants is to teach counties how to use existing programs that capture federal financial participation to meet the needs of eligible persons who are deafblind and to build capacity of senior service programs to meet the needs of seniors with a dual sensory hearing and vision loss.

(b) The commissioner may make grants:

(1) for services and training provided by organizations; and

(2) to develop and administer consumer-directed services.

(c) Consumer-directed services shall be provided in whole by grant-funded providers. The Deaf and Hard-of-Hearing Services Division's regional service centers shall not provide any aspect of a grant-funded consumer-directed services program.

(d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant under paragraph (a).

(e) Deafblind service providers may, but are not required to, provide intervenor services as part of the service package provided with grant funds under this section. Intervener services include services provided by a family and community intervener as described in paragraph (f).

(f) The family and community intervener, as defined in section 256C.23, subdivision 7, provides services to open channels of communication between the child and others; facilitate the development or use of receptive and expressive communication skills by the child; and develop and maintain a trusting, interactive relationship that promotes social and emotional well-being. The family and community intervener also provides access to information and the environment, and facilitates opportunities for learning and development. A family and community intervener must have specific training in deafblindness, building language and communication skills, and intervention strategies.

Sec. 52. Minnesota Statutes 2018, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to individuals in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with

transportation, arranging for meetings and appointments, and arranging for medical and social services, and services identified in section 256I.03, subdivision 12.

Sec. 53. Minnesota Statutes 2018, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of housing support;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury; ~~and~~

(6) submission of residency requirements that could result in recipient eviction~~.~~; and

(7) confirmation that the provider will not limit or restrict the number of hours an applicant or recipient chooses to be employed, as specified in subdivision 5.

(c) Agreements may be terminated with or without cause by the commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

Sec. 54. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

Subd. 2h. **Required supplementary services.** Providers of supplementary services shall ensure that recipients have, at a minimum, assistance with services as identified in the recipient's professional statement of need under section 256I.03, subdivision 12. Providers of supplementary services shall maintain case notes with the date and description of services provided to individual recipients.

Sec. 55. Minnesota Statutes 2018, section 256I.04, is amended by adding a subdivision to read:

Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number of hours an applicant or recipient is employed.

Sec. 56. Minnesota Statutes 2018, section 256I.05, subdivision 1r, is amended to read:

Subd. 1r. **Supplemental rate; Anoka County.** (a) Notwithstanding the provisions in this section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider that is located in Anoka County and provides emergency housing on the former Anoka Regional Treatment Center campus.

(b) Notwithstanding the provisions in this section, a county agency shall negotiate a supplemental rate for six beds in addition to the rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision 1a, including any legislatively authorized inflationary adjustments, for a housing support provider located in Anoka County that operates a 12-bed facility and provides room and board and supplementary services to individuals 18 to 24 years of age.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 57. **[268A.061] HOME AND COMMUNITY-BASED PROVIDERS.**

Subdivision 1. **Home and community-based provider eligibility for payments.** Notwithstanding Minnesota Rules, part 3300.5060, subparts 14 to 16, the commissioner shall make payments for job-related services, vocational adjustment training, and vocational evaluation services to any home and community-based services provider licensed as an intensive support services provider under chapter 245D with whom the commissioner has signed a limited-use vendor operating agreement.

Subd. 2. **Limited-use agreements with home and community-based providers.** A limited-use vendor operating agreement under this section may not limit the dollar amount the provider may receive annually. The limited-use vendor operating agreement available under this section must specify at a minimum that payments under the agreement are limited to vocational rehabilitation services provided to individuals to whom the provider has previously provided day services as described under section 245D.03, subdivision 1, paragraph (c), clause (4), or any of the employment services described under section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7).

Subd. 3. **Required limited-use agreements.** The commissioner must enter into a limited-use vendor operating agreement that meets at least the minimal requirements of subdivision 2 with a provider eligible under subdivision 1 if:

(1) the home and community-based provider is not a current vocational rehabilitation services provider;

(2) each individual to be served under the limited-use vendor operating agreement was receiving day or employment services from the provider immediately prior to the provider serving the individual under the terms of the agreement; and

(3) each individual to be served under the limited-use vendor operating agreement has made an informed choice to remain with the provider.

Sec. 58. Laws 2017, First Special Session chapter 6, article 1, section 44, is amended to read:

Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to expand the exception to the consumer-directed community supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants who have a coordinated service and support plan which identifies the need for an increased amount of services or supports under consumer-directed community supports than the amount they are currently receiving under the consumer-directed community supports budget methodology:

(i) to increase the amount of time a person works or otherwise improves employment opportunities;

(ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes, section 256D.44, subdivision 5, ~~paragraph (f), clause (1), item (ii), or~~ paragraph (g), clause (1), item (iii); or

(iii) to develop and implement a positive behavior support plan; or

(2) home and community-based waiver participants who are currently using licensed providers for (i) employment supports or services during the day; or (ii) residential services, either of which cost more annually than the person would spend under a consumer-directed community supports plan for any or all of the supports needed to meet the goals identified in paragraph (a), clause (1), items (i), (ii), and (iii).

(b) The exception under paragraph (a), clause (1), is limited to those persons who can demonstrate that they will have to discontinue using consumer-directed community supports and accept other non-self-directed waiver services because their supports needed for the goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within the consumer-directed community supports budget limits.

(c) The exception under paragraph (a), clause (2), is limited to those persons who can demonstrate that, upon choosing to become a consumer-directed community supports participant, the total cost of services, including the exception, will be less than the cost of current waiver services.

Sec. 59. Laws 2017, First Special Session chapter 6, article 1, section 45, is amended to read:

Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY ~~EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND CRISIS RESIDENTIAL SETTINGS~~.**

Subdivision 1. **Exception for persons leaving institutions and crisis residential settings.** (a) By September 30, 2017, the commissioner shall establish an institutional and crisis bed consumer-directed community supports budget exception process in the home and community-based services waivers under Minnesota Statutes, sections 256B.092 and 256B.49. This budget exception process shall be available for any individual who:

(1) is not offered available and appropriate services within 60 days since approval for discharge from the individual's current institutional setting; and

(2) requires services that are more expensive than appropriate services provided in a noninstitutional setting using the consumer-directed community supports option.

(b) Institutional settings for purposes of this exception include intermediate care facilities for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget exception shall be limited to no more than the amount of appropriate services provided in a noninstitutional setting as determined by the lead agency managing the individual's home and community-based services waiver. The lead agency shall notify the Department of Human Services of the budget exception.

Subd. 2. **Shared services.** (a) Medical assistance payments for shared services under consumer-directed community supports are limited to this subdivision.

(b) For purposes of this subdivision, "shared services" means services provided at the same time by the same direct care worker for individuals who have entered into an agreement to share consumer-directed community support services.

(c) Shared services may include services in the personal assistance category as outlined in the consumer-directed community supports community support plan and shared services agreement, except:

(1) services for more than three individuals provided by one worker at one time;

(2) use of more than one worker for the shared services; and

(3) a child care program licensed under chapter 245A or operated by a local school district or private school.

(d) The individuals or, as needed, their representatives shall develop the plan for shared services when developing or amending the consumer-directed community supports plan, and must follow the consumer-directed community supports process for approval of the plan by the lead agency. The plan for shared services in an individual's consumer-directed community supports plan shall include the intention to utilize shared services based on individuals' needs and preferences.

(e) Individuals sharing services must use the same financial management services provider.

(f) Individuals whose consumer-directed community supports community support plans include the intention to utilize shared services must also jointly develop, with the support of their representatives as needed, a shared services agreement. This agreement must include:

(1) the names of the individuals receiving shared services;

(2) the individuals' representative, if identified in their consumer-directed community supports plans, and their duties;

(3) the names of the case managers;

(4) the financial management services provider;

(5) the shared services that must be provided;

(6) the schedule for shared services;

(7) the location where shared services must be provided;

(8) the training specific to each individual served;

(9) the training specific to providing shared services to the individuals identified in the agreement;

(10) instructions to follow all required documentation for time and services provided;

(11) a contingency plan for each of the individuals that accounts for service provision and billing in the absence of one of the individuals in a shared services setting due to illness or other circumstances;

(12) signatures of all parties involved in the shared services; and

(13) agreement by each of the individuals who are sharing services on the number of shared hours for services provided.

(g) Any individual or any individual's representative may withdraw from participating in a shared services agreement at any time.

(h) The lead agency for each individual must authorize the use of the shared services option based on the criteria that the shared service is appropriate to meet the needs, health, and safety of each individual for whom they provide case management or care coordination.

(i) Nothing in this subdivision must be construed to reduce the total authorized consumer-directed community supports budget for an individual.

(j) No later than September 30, 2019, the commissioner of human services shall:

(1) submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to allow for a shared services option under consumer-directed community supports; and

(2) with stakeholder input, develop guidance for shared services in consumer-directed community-supports within the Community Based Services Manual. Guidance must include:

(i) recommendations for negotiating payment for one-to-two and one-to-three services; and

(ii) a template of the shared services agreement.

EFFECTIVE DATE. This section is effective October 1, 2019, or upon federal approval, whichever is later, except for subdivision 2, paragraph (j), which is effective the day following final enactment. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 60. **DAY TRAINING AND HABILITATION DISABILITY WAIVER RATE SYSTEM TRANSITION GRANTS.**

(a) The commissioner of human services shall establish annual grants to day training and habilitation providers that are projected to experience a funding gap upon the full implementation of Minnesota Statutes, section 256B.4914.

(b) In order to be eligible for a grant under this section, a day training and habilitation disability waiver provider must:

(1) serve at least 100 waiver service participants;

(2) be projected to receive a reduction in annual revenue from medical assistance for day services during the first year of full implementation of disability waiver rate system framework rates under Minnesota Statutes, section 256B.4914, of at least 15 percent and at least $300,000 compared to the annual medical assistance revenue for day services the provider received during the last full year during which banded rates under Minnesota Statutes, section 256B.4913, subdivision 4a, were effective; and

(3) agree to develop, submit, and implement a sustainability plan as provided in paragraph

(c) A recipient of a grant under this section must develop a sustainability plan in partnership with the commissioner of human services. The sustainability plan must include:

(1) a review of all the provider's costs and an assessment of whether the provider is implementing available cost-control options appropriately;

(2) a review of all the provider's revenue and an assessment of whether the provider is leveraging available resources appropriately; and

(3) a practical strategy for closing the funding gap described in paragraph (b), clause (2).

(d) The commissioner of human services shall provide technical assistance and financial management advice to grant recipients as they develop and implement their sustainability plans.

(e) In order to be eligible for an annual grant renewal, a grant recipient must demonstrate to the commissioner of human services that it made a good faith effort to close the revenue gap described in paragraph (b), clause (2).

Sec. 61. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MNCHOICES 2.0.**

(a) The commissioner of human services must ensure that the MnCHOICES 2.0 assessment and support planning tool incorporates a qualitative approach with open-ended questions and a conversational, culturally sensitive approach to interviewing that captures the assessor's professional judgment based on the person's responses.

(b) If the commissioner of human services convenes a working group or consults with stakeholders for the purposes of modifying the assessment and support planning process or tool, the commissioner must include members of the disability community, including representatives of organizations and individuals involved in assessment and support planning.

(c) Until MnCHOICES 2.0 is fully implemented, the commissioner shall permit counties to use the most recent legacy documents related to long-term service and supports assessments and shall reimburse counties in the same amount as the commissioner would were the county using the MnCHOICES assessment tool.

Sec. 62. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PAYMENTS FOR COUNTY HUMAN SERVICES ACTIVITIES.**

By December 1, 2019, the commissioner of human services shall provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy proposing a rate per assessment to be paid to counties and tribes for all medical assistance and county human services activities currently reimbursed via a random moment time study. The commissioner, in developing the proposal, shall use past estimates of time spent on each relevant activity. The commissioner's report shall include an explanation of how the commissioner determines the portion of capitated rates paid to health plans attributable to each type of activity also performed by a county or tribe.

The commissioner's proposal must include a single rate per activity for each activity for all populations, but may also include an alternative proposal for different rates per activity for each activity for different populations.

Sec. 63. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; BARRIERS TO INDEPENDENT LIVING.**

By December 1, 2019, the commissioner of human services shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy a report describing state and federal regulatory barriers, including provisions of the Fair Housing Act, that create barriers to independent living for persons with disabilities. In developing the report, the commissioner shall consult with stakeholders, including individuals with disabilities, advocacy organizations, and service providers.

Sec. 64. **ADULT FOSTER CARE MORATORIUM EXEMPTION.**

An adult foster care setting located in Elk River, Sherburne County, and licensed in 2003 to serve four people is exempt from the moratorium under Minnesota Statutes, section 245A.03, subdivision 7, until July 1, 2020.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 65. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN COUNTY.**

(a) The commissioner of human services shall allow a housing with services establishment located in Minneapolis that provides customized living and 24-hour customized living services for clients enrolled in the brain injury (BI) or community access for disability inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer service capacity of up to 66 clients to no more than three new housing with services establishments located in Hennepin County.

(b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall determine that the new housing with services establishments described under paragraph (a) meet the BI and CADI waiver customized living and 24-hour customized living size limitation exception for clients receiving those services at the new housing with services establishments described under paragraph (a).

Sec. 66. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; PERSONAL CARE ASSISTANCE SERVICES COMPARABILITY WAIVER.**

The commissioner of human services shall submit by July 1, 2019, a waiver request to the Centers for Medicare and Medicaid Services to allow people receiving personal care assistance services as of December 31, 2019, to continue their eligibility for personal care assistance services under the personal care assistance service eligibility criteria in effect on December 31, 2019.

Sec. 67. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; TRANSITION PERIOD FOR MODIFIED ELIGIBILITY OF PERSONAL CARE ASSISTANCE.**

(a) Beginning at the latest date permissible under federal law, the modified eligibility criteria under Minnesota Statutes, section 256B.0625, subdivision 19a, and Minnesota Statutes, section 256B.0652, subdivision 6, paragraphs (b) and (d), shall apply on a rolling basis, at the time of annual assessments, to people receiving personal care assistance as of December 31, 2019.

(b) The commissioner shall establish a transition period for people receiving personal care assistance services as of December 31, 2019, who, at the time of the annual assessment described in paragraph (a), are determined to be ineligible for personal care assistance services. Service authorizations for this transition period shall not exceed one year.

EFFECTIVE DATE. This section is effective January 1, 2020, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval is obtained and when personal care assistance services provided under paragraph (b) have expired.

Sec. 68. **DIRECTION TO THE COMMISSIONER; REPORT ON ELIGIBILITY FOR PERSONAL CARE ASSISTANCE AND ACCESS TO DEVELOPMENTAL DISABILITIES AND COMMUNITY ACCESS FOR DISABILITY INCLUSION WAIVERS.**

By December 15, 2020, the commissioner shall submit a report to chairs and ranking minority members of the legislative committees with jurisdiction over human services on modifications to the eligibility criteria for the personal care assistance program and limits on the growth of the developmental disabilities and community access for disability inclusion waivers enacted following the 2019 legislative session. The report shall include the impact on people receiving or requesting services and any recommendations. By February 15, 2021,

the commissioner shall supplement the December 15, 2020, report with updated data and information.

Sec. 69. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; INTERMEDIATE CARE FACILITY FOR PERSONS WITH DEVELOPMENTAL DISABILITIES LEVEL OF CARE CRITERIA.**

By February 1, 2020, the commissioner of human services shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy recommended language to codify in Minnesota Statutes the commissioner's existing criteria for the determination of need for intermediate care facility for persons with developmental disabilities level of care. The recommended language shall include language clarifying "at risk of placement," "reasonable indication," and "might require" as those expressions are used in Minnesota Statutes, section 256B.092, subdivision 7, paragraph (b). The recommended statutory language shall also include the commissioner's current guidance with respect to the interpretation and application of the federal standard under Code of Federal Regulations, title 42, section 483.440, that a person receiving the services of an intermediate care facility for persons with developmental disabilities require a continuous active treatment plan, including which characteristics are necessary or sufficient for a determination of a need for active treatment. The commissioner shall submit the recommended statutory language with a letter listing, with statutory references, all the programs and services for which an intermediate care facility for persons with developmental disabilities level of care is required.

Sec. 70. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DIRECT CARE WORKFORCE RATE METHODOLOGY STUDY.**

The commissioner of human services, in consultation with stakeholders, shall evaluate the feasibility of developing a rate methodology for the personal care assistance program under Minnesota Statutes, section 256B.0659, and community first services and supports under Minnesota Statutes, section 256B.85, similar to the disability waiver rate system under Minnesota Statutes, section 256B.4914, including determining the component values and factors to include in such a rate methodology; consider aligning any rate methodology with the collective bargaining agreement and negotiation cycle under Minnesota Statutes, section 179A.54; recommend strategies for ensuring adequate, competitive wages for direct care workers; develop methods and determine the necessary resources for the commissioner to more consistently collect and audit data from the direct care industry; and report recommendations, including proposed draft legislation, to the chairs and ranking minority

members of the legislative committees with jurisdiction over human services policy and finance by February 1, 2020.

Sec. 71. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; HOME CARE SERVICES PAYMENT REFORM PROPOSAL.**

The commissioner of human services shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy a proposal to adopt a budget-neutral prospective payment system for nursing services and home health services under Minnesota Statutes, sections 256B.0625, subdivision 6a, and 256B.0653, and home care nursing services under Minnesota Statutes, sections 256B.0625, subdivision 7, and 256B.0624, modeled on the Medicare fee-for-service home health prospective payment system. The commissioner shall include in the proposal a case mix adjusted episodic rate, including services, therapies and supplies, minimum visits required for an episodic rate, consolidated billing requirements, outlier payments, low-utilization payments, and other criteria at the commissioner's discretion. In addition to the budget-neutral payment reform proposal, the commissioner shall also submit a proposed mechanism for updating the payment rates to reflect inflation in health care costs.

Sec. 72. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "developmental disability waiver" or similar terms to "developmental disabilities waiver" or similar terms wherever they appear in Minnesota Statutes. The revisor shall also make technical and other necessary changes to sentence structure to preserve the meaning of the text.

(b) The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research and Fiscal Analysis, and Department of Human Services, shall prepare legislation for the 2020 legislative session to codify existing session laws governing consumer-directed community supports in Minnesota Statutes, chapter 256B.

Sec. 73. **REPEALER.**

Minnesota Statutes 2018, section 256I.05, subdivision 3, is repealed.

ARTICLE 6
DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2018, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Administrative review of county liability for cost of care.** (a) The county of financial responsibility may submit a written request for administrative review by the commissioner of the county's payment of the cost of care when a delay in discharge of a client from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility results from the following actions by the facility:

(1) the facility did not provide notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged;

(2) the notice to the county that the facility has determined that it is clinically appropriate for a client to be discharged was communicated on a holiday or weekend;

(3) the required documentation or procedures for discharge were not completed in order for the discharge to occur in a timely manner; or

(4) the facility disagrees with the county's discharge plan.

(b) The county of financial responsibility may not appeal the determination that it is clinically appropriate for a client to be discharged from a regional treatment center, state-operated community-based behavioral health hospital, or other state-operated facility.

(c) The commissioner must evaluate the request for administrative review and determine if the facility's actions listed in paragraph (a) caused undue delay in discharging the client. If the commissioner determines that the facility's actions listed in paragraph (a) caused undue delay in discharging the client, the county's liability will be reduced to the level of the cost of care for a client whose stay in a facility is determined to be clinically appropriate, effective on the date of the facility's action or failure to act that caused the delay. The commissioner's determination under this subdivision is final.

(d) If a county's liability is reduced pursuant to paragraph (c), a county's liability will return to the level of the cost of care for a client whose stay in a facility is determined to no longer be appropriate effective on the date the facility rectifies the action or failure to act that caused the delay under paragraph (a).

(e) Any difference in the county cost of care liability resulting from administrative review under this subdivision shall not be billed to the client or applied to future reimbursement from the client's estate or relatives.

Sec. 2. **DIRECTION TO COMMISSIONER; REPORT REQUIRED; DISCHARGE DELAY REDUCTION.**

No later than January 1, 2023, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services that provides an update on county and state efforts to reduce the number of days clients spend in state-operated facilities after discharge from the facility has been determined to be clinically appropriate. The report must also include information on the fiscal impact of clinically inappropriate stays in these facilities.

Sec. 3. **DIRECTION TO COMMISSIONER; MSOCS COON RAPIDS ILEX CLOSURE.**

The commissioner of human services shall close the Minnesota state-operated community services program known as MSOCS Coon Rapids Ilex. The commissioner must not reopen or redesign the program. For the purposes of this section:

(1) a program is considered closed if the commissioner discontinues providing services at a given location;

(2) a program is considered reopened if the commissioner opens a new program or begins providing a new service at a location that was previously closed; and

(3) a program is considered redesigned if the commissioner does not change the nature of the services provided, but does change the focus of the population served by the program.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. **REPEALER.**

Minnesota Statutes 2018, section 246.18, subdivisions 8 and 9, are repealed.

ARTICLE 7
OPERATIONS

Section 1. Minnesota Statutes 2018, section 16A.055, subdivision 1a, is amended to read:

Subd. 1a. **Additional duties.** The commissioner may assist state agencies by providing analytical, statistical, program evaluation using experimental or quasi-experimental design, and organizational development services to state agencies in order to assist the agency to achieve the agency's mission and to operate efficiently and effectively. For purposes of this section, "experimental design" means a method of evaluating the impact of a service that

uses random assignment to assign participants into groups that respectively receive the studied service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service; and

"quasi-experimental design" means a method of evaluating the impact of a service that uses strategies other than random assignment to establish statistically similar groups that respectively receive the service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service.

Sec. 2. Minnesota Statutes 2018, section 245A.04, subdivision 7, is amended to read:

Subd. 7. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 245A.043. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

(3) the effective date and expiration date of the license;

(4) the type of license;

(5) the maximum number and ages of persons that may receive services from the program; and

(6) any special conditions of licensure.

(b) The commissioner may issue ~~an initial~~ a license for a period not to exceed two years if:

(1) the commissioner is unable to conduct the evaluation or observation required by subdivision 4, paragraph (a), clauses (3) and (4), because the program is not yet operational;

(2) certain records and documents are not available because persons are not yet receiving services from the program; and

(3) the applicant complies with applicable laws and rules in all other respects.

(c) A decision by the commissioner to issue a license does not guarantee that any person or persons will be placed or cared for in the licensed program. ~~A license shall not be transferable to another individual, corporation, partnership, voluntary association, other organization, or controlling individual or to another location.~~

~~(d) A license holder must notify the commissioner and obtain the commissioner's approval before making any changes that would alter the license information listed under paragraph (a).~~

~~(e)~~ (d) Except as provided in paragraphs ~~(g)~~ (f) and ~~(h)~~ (g), the commissioner shall not issue or reissue a license if the applicant, license holder, or controlling individual has:

(1) been disqualified and the disqualification was not set aside and no variance has been granted;

(2) been denied a license within the past two years;

(3) had a license issued under this chapter revoked within the past five years;

(4) an outstanding debt related to a license fee, licensing fine, or settlement agreement for which payment is delinquent; or

(5) failed to submit the information required of an applicant under subdivision 1, paragraph (f) or (g), after being requested by the commissioner.

When a license issued under this chapter is revoked under clause (1) or (3), the license holder and controlling individual may not hold any license under chapter 245A or 245D for five years following the revocation, and other licenses held by the applicant, license holder, or controlling individual shall also be revoked.

~~(f)~~ (e) The commissioner shall not issue or reissue a license under this chapter if an individual living in the household where the ~~licensed~~ services will be provided as specified under section 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside and no variance has been granted.

~~(g)~~ (f) Pursuant to section 245A.07, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

~~(h)~~ (g) Notwithstanding paragraph ~~(g)~~ (f), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating

compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

~~(i)~~ (h) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

~~(j)~~ (i) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date.

~~(k)~~ (j) The commissioner shall not issue or reissue a license under this chapter if it has been determined that a tribal licensing authority has established jurisdiction to license the program or service.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 3. Minnesota Statutes 2018, section 245A.04, is amended by adding a subdivision to read:

Subd. 7a. **Notification required.** (a) A license holder must notify the commissioner and obtain the commissioner's approval before making any change that would alter the license information listed under subdivision 7, paragraph (a).

(b) At least 30 days before the effective date of a change, the license holder must notify the commissioner in writing of any change:

(1) to the license holder's controlling individual as defined in section 245A.02, subdivision 5a;

(2) to license holder information on file with the secretary of state;

(3) in the location of the program or service licensed under this chapter; and

(4) in the federal or state tax identification number associated with the license holder.

(c) When a license holder notifies the commissioner of a change to the business structure governing the licensed program or services but is not selling the business, the license holder must provide amended articles of incorporation and other documentation of the change and any other information requested by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 4. **[245A.043] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.**

Subdivision 1. **Transfer prohibited.** A license issued under this chapter is only valid for a premises and individual, organization, or government entity identified by the commissioner on the license. A license is not transferable or assignable.

Subd. 2. **Change of ownership.** If the commissioner determines that there will be a change of ownership, the commissioner shall require submission of a new license application. A change of ownership occurs when:

(1) the license holder sells or transfers 100 percent of the property, stock, or assets;

(2) the license holder merges with another organization;

(3) the license holder consolidates with two or more organizations, resulting in the creation of a new organization;

(4) there is a change in the federal tax identification number associated with the license holder; or

(5) there is a turnover of each controlling individual associated with the license within a 12-month period. A change to the license holder's controlling individuals, including a change due to a transfer of stock, is not a change of ownership if at least one controlling individual who was listed on the license for at least 12 consecutive months continues to be a controlling individual after the reported change.

Subd. 3. **Change of ownership requirements.** (a) A license holder who intends to change the ownership of the program or service under subdivision 2 to a party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service must provide the commissioner with written notice of the proposed sale or change, on a form provided by the commissioner, at least 60 days before the anticipated date of the change in ownership. For purposes of this subdivision and subdivision 4, "party" means the party that intends to operate the service or program.

(b) The party must submit a license application under this chapter on the form and in the manner prescribed by the commissioner at least 30 days before the change of ownership

is complete and must include documentation to support the upcoming change. The form and manner of the application prescribed by the commissioner shall require only information which is specifically required by statute or rule. The party must comply with background study requirements under chapter 245C and shall pay the application fee required in section 245A.10. A party that intends to assume operation without an interruption in service longer than 60 days after acquiring the program or service is exempt from the requirements of Minnesota Rules, part 9530.6800.

(c) The commissioner may develop streamlined application procedures when the party is an existing license holder under this chapter and is acquiring a program licensed under this chapter or service in the same service class as one or more licensed programs or services the party operates and those licenses are in substantial compliance according to the licensing standards in this chapter and applicable rules. For purposes of this subdivision, "substantial compliance" means within the past 12 months the commissioner did not: (i) issue a sanction under section 245A.07 against a license held by the party or (ii) make a license held by the party conditional according to section 245A.06.

(d) Except when a temporary change of ownership license is issued pursuant to subdivision 4, the existing license holder is solely responsible for operating the program according to applicable rules and statutes until a license under this chapter is issued to the party.

(e) If a licensing inspection of the program or service was conducted within the previous 12 months and the existing license holder's license record demonstrates substantial compliance with the applicable licensing requirements, the commissioner may waive the party's inspection required by section 245A.04, subdivision 4. The party must submit to the commissioner proof that the premises was inspected by a fire marshal or that the fire marshal deemed that an inspection was not warranted and proof that the premises was inspected for compliance with the building code or that no inspection was deemed warranted.

(f) If the party is seeking a license for a program or service that has an outstanding correction order, the party must submit a letter with the license application identifying how and within what length of time the party shall resolve the outstanding correction order and come into full compliance with the licensing requirements.

(g) Any action taken under section 245A.06 or 245A.07 against the existing license holder's license at the time the party is applying for a license, including when the existing license holder is operating under a conditional license or is subject to a revocation, shall

remain in effect until the commissioner determines that the grounds for the action are corrected or no longer exist.

(h) The commissioner shall evaluate the application of the party according to section 245A.04, subdivision 6. Pursuant to section 245A.04, subdivision 7, if the commissioner determines that the party complies with applicable laws and rules, the commissioner may issue a license or a temporary change of ownership license.

(i) The commissioner may deny an application as provided in section 245A.05. An applicant whose application was denied by the commissioner may appeal the denial according to section 245A.05.

(j) This subdivision does not apply to a licensed program or service located in a home where the license holder resides.

Subd. 4. **Temporary change of ownership license.** (a) After receiving the party's application and upon the written request of the existing license holder and the party, the commissioner may issue a temporary change of ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may establish criteria to issue a temporary change of ownership license, if a license holder's death, divorce, or other event affects the ownership of the program, when an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated. This subdivision applies to any program or service licensed under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 5. Minnesota Statutes 2018, section 245A.065, is amended to read:

245A.065 CHILD CARE FIX-IT TICKET.

Subdivision 1. **Contents of fix-it tickets.** (a) In lieu of a correction order under section 245A.06, the commissioner ~~shall~~ may issue a fix-it ticket to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503~~, that the commissioner determines to be eligible for a fix-it ticket~~;

(2) the violation does not imminently endanger the health, safety, or rights of the persons served by the program;

(3) the license holder did not receive a fix-it ticket or correction order for the violation at the license holder's last licensing inspection; and

(4) the violation ~~can~~ cannot be corrected at the time of inspection~~ or within 48 hours, excluding Saturdays, Sundays, and holidays; and~~

~~(5) the license holder corrects the violation at the time of inspection or agrees to correct the violation within 48 hours, excluding Saturdays, Sundays, and holidays~~.

(b) The commissioner shall not issue a fix-it ticket for violations that are corrected at the time of the inspection.

(c) The fix-it ticket must state:

(1) the conditions that constitute a violation of the law or rule;

(2) the specific law or rule violated; and

(3) that the violation ~~was corrected at the time of inspection or~~ must be corrected within 48 hours, excluding Saturdays, Sundays, and holidays.

~~(c)~~ (d) The commissioner shall not publicly publish a fix-it ticket on the department's website.

~~(d)~~ (e) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it ticket, the license holder must correct the violation and within one week submit evidence to the licensing agency that the violation was corrected.

~~(e)~~ (f) If the violation is not corrected ~~at the time of inspection or~~ within 48 hours, excluding Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that the license holder corrected the violation, the commissioner must issue a correction order, according to section 245A.06, for the violation of Minnesota law or rule identified in the fix-it ticket ~~according to section 245A.06~~.

~~(f) The commissioner shall, following consultation with family child care license holders, child care center license holders, and county agencies, issue a report by October 1, 2017, that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503, that are eligible for a fix-it ticket. The commissioner shall provide the report to county~~

~~agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over child care, and shall post the report to the department's website.~~

Subd. 2. **Fix-it ticket laws and rules.** (a) For family child care license holders, violations of the following laws and rules may qualify only for a fix-it ticket: 9502.0335, subpart 10; 9502.0375, subpart 2; 9502.0395; 9502.0405, subpart 3; 9502.0405, subpart 4, item A; 9502.0415, subpart 3; 9502.0425, subpart 2 (outdoor play spaces must be free from litter, rubbish, unlocked vehicles, or human or animal waste); 9502.0425, subpart 3 (wading pools must be kept clean); 9502.0425, subpart 5; 9502.0425, subpart 7, item F (screens on exterior doors and windows when biting insects are prevalent); 9502.0425, subpart 8; 9502.0425, subpart 10; 9502.0425, subpart 11 (decks free of splinters); 9502.0425, subpart 13 (toilets flush thoroughly); 9502.0425, subpart 16; 9502.0435, subpart 1; 9502.0435, subpart 3; 9502.0435, subpart 7; 9502.0435, subpart 8, item B; 9502.0435, subpart 8, item E; 9502.0435, subpart 12, items A through E; 9502.0435, subpart 13; 9502.0435, subpart 14; 9502.0435, subpart 15; 9502.0435, subpart 15, items A and B; 9502.0445, subpart 1, item B; 9502.0445, subpart 3, items B through D; 9502.0445, subpart 4, items A through C; 245A.04, subdivision 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.146, subdivision 3, paragraph (c); 245A.148; 245A.152; 245A.50, subdivision 7; 245A.51, subdivision 3, paragraph (d) (emergency preparedness plan available for review and posted in prominent location).

(b) For child care center license holders, violations of the following laws and rules may qualify only for a fix-it ticket: 9503.0120, item B; 9503.0120, item E; 9503.0125, item E; 9503.0125, item F; 9503.0125, item I; 9503.0125, item M; 9503.0140, subpart 2; 9503.0140, subpart 7, item D; 9503.0140, subpart 9; 9503.0140, subpart 10; 9503.0140, subpart 13; 9503.0140, subpart 14; 9503.0140, subpart 15; 9503.0140, subpart 16 (item missing from first-aid kit); 9503.0140, subpart 18; 9503.0140, subpart 19; 9503.0140, subpart 20; 9503.0140, subpart 21 (emergency plan not posted in prominent place); 9503.0145, subpart 2; 9503.0145, subpart 3; 9503.0145, subpart 4, item D; 9503.0145, subpart 8 (drinking water provided in single service cups or at an accessible drinking fountain); 9503.0155, subpart 7, item D; 9503.0155, subpart 13; 9503.0155, subpart 16; 9503.0155, subpart 17; 9503.0155, subpart 18, item D; 9503.0170, subpart 3; 9503.0145, subpart 7, item D; 245A.04, subdivision 14, paragraph (c); 245A.06, subdivision 8; 245A.07, subdivision 5; 245A.14, subdivision 8, paragraph (b) (experienced aide identification posting); 245A.146, subdivision 3, paragraph (c); 245A.152; 245A.41, subdivision 3, paragraph (d); 245A.41, subdivision 3, paragraph (e); 245A.41, subdivision 3, paragraph (f).

Sec. 6. Minnesota Statutes 2018, section 245C.02, is amended by adding a subdivision to read:

Subd. 20. **Substance use disorder treatment field.** "Substance use disorder treatment field" means a program exclusively serving individuals 18 years of age and older and that is required to be:

(1) licensed under chapter 245G; or

(2) registered under section 157.17 as a board and lodge establishment that predominantly serves individuals being treated for or recovering from a substance use disorder.

Sec. 7. Minnesota Statutes 2018, section 245C.22, subdivision 4, is amended to read:

Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification if the commissioner finds that the individual has submitted sufficient information to demonstrate that the individual does not pose a risk of harm to any person served by the applicant, license holder, or other entities as provided in this chapter.

(b) In determining whether the individual has met the burden of proof by demonstrating the individual does not pose a risk of harm, the commissioner shall consider:

(1) the nature, severity, and consequences of the event or events that led to the disqualification;

(2) whether there is more than one disqualifying event;

(3) the age and vulnerability of the victim at the time of the event;

(4) the harm suffered by the victim;

(5) vulnerability of persons served by the program;

(6) the similarity between the victim and persons served by the program;

(7) the time elapsed without a repeat of the same or similar event;

(8) documentation of successful completion by the individual studied of training or rehabilitation pertinent to the event; and

(9) any other information relevant to reconsideration.

(c) If the individual requested reconsideration on the basis that the information relied upon to disqualify the individual was incorrect or inaccurate and the commissioner determines that the information relied upon to disqualify the individual is correct, the commissioner

must also determine if the individual poses a risk of harm to persons receiving services in accordance with paragraph (b).

(d) For an individual seeking employment in the substance use disorder treatment field, the commissioner shall set aside the disqualification if the following criteria are met:

(1) the individual is not disqualified for a crime of violence as listed under section 624.712, subdivision 5, except that the following crimes are prohibitory offenses: crimes listed under section 152.021, subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

(2) the individual is not disqualified under section 245C.15, subdivision 1;

(3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph (b);

(4) the individual provided documentation of successful completion of treatment, at least one year prior to the date of the request for reconsideration, at a program licensed under chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after the successful completion of treatment;

(5) the individual provided documentation demonstrating abstinence from controlled substances, as defined in section 152.01, subdivision 4, for the period of one year prior to the date of the request for reconsideration; and

(6) the individual is seeking employment in the substance use disorder treatment field.

Sec. 8. Minnesota Statutes 2018, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 254C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

~~(c)~~ (d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 9. **[245I.01] OFFICE OF INSPECTOR GENERAL.**

Subdivision 1. **Creation.** A state Office of Inspector General is created.

Subd. 2. **Director.** (a) The office shall be under the direction of an inspector general who shall be appointed by the governor, with the advice and consent of the senate, for a term ending on June 30 of the sixth calendar year after appointment. Senate confirmation of the inspector general shall be as provided by section 15.066. The inspector general shall appoint deputies to serve in the office as necessary to fulfill the duties of the office. The inspector general may delegate to a subordinate employee the exercise of a specified statutory power or duty, subject to the control of the inspector general. Every delegation must be by written order filed with the secretary of state.

(b) The inspector general shall be in the unclassified service, but may be removed only for cause.

Subd. 3. **Duties.** The inspector general shall, in coordination with counties where applicable:

(1) develop and maintain the licensing and regulatory functions related to hospitals, boarding care homes, outpatient surgical centers, birthing centers, nursing homes, home care agencies, supplemental nursing services agencies, hospice providers, housing with services establishments, assisted living facilities, prescribed pediatric extended care centers, and board and lodging establishments with special services consistent with chapters 144A, 144D, 144G, and 144H, and sections 144.50 to 144.58, 144.615, and 157.17;

(2) notwithstanding the requirement under section 144A.52, subdivision 1, that the director of the Office of Health Facility Complaints be appointed by the commissioner of health, assume the role of director of the Office of Health Facility Complaints;

(3) develop and maintain the licensing and regulatory functions related to adult day care, child care and early education, children's residential facilities, foster care, home and community-based services, independent living assistance for youth, outpatient mental health clinics or centers, residential mental health treatment for adults, and substance use disorder treatment consistent with chapters 245, 245A, 245D, 245F, 245G, 245H, 252, and 256;

(4) conduct background studies according to sections 144.057, 144A.476, 144A.62, 144A.754, and 157.17 and chapter 245C. For the purpose of completing background studies, the inspector general shall have authority to access maltreatment data maintained by local welfare agencies or agencies responsible for assessing or investigating reports under section 626.556, and names of substantiated perpetrators related to maltreatment of vulnerable adults maintained by the commissioner of human services under section 626.557;

(5) develop and maintain the background study requirements consistent with chapter 245C;

(6) be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, providers, and other participants in the human services programs administered by the Department of Human Services;

(7) require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the Department of Human Services; and

(8) develop, maintain, and administer the common entry point established on July 1, 2015, under section 626.557, subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 10. **[245I.02] TRANSFER OF DUTIES.**

Subdivision 1. **Transfer and reorganization orders.** (a) Section 15.039 applies to the transfer of duties required by this chapter.

(b) For an employee affected by the transfer of duties required by this chapter, the seniority accrued by the employee at the employee's former agency transfers to the employee's new agency.

Subd. 2. **Transfer of duties from the commissioner of human services.** The commissioner of administration, with approval of the governor, may issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties of the commissioner of human services required by this chapter. The provision of section 16B.37, subdivision 1, stating that transfers under that section may be made only to an agency that has been in existence for at least one year does not apply to transfers to an agency created by this chapter.

Subd. 3. **Transfer of duties from the commissioner of health.** The commissioner of administration, with approval of the governor, may issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties of the commissioner of health required by this chapter. The provision of section 16B.37, subdivision 1, stating that transfers under that section may be made only to an agency that has been in existence for at least one year does not apply to transfers to an agency created by this chapter.

Subd. 4. **Aggregate cost limit.** The commissioner of management and budget must ensure that the aggregate cost for the inspector general of the Office of Inspector General is not more than the aggregate cost of the primary executives in the Office of Inspector General at the Department of Human Services and the Health Regulation Division at the Department of Health immediately before the effective date of subdivision 2.

EFFECTIVE DATE. Subdivisions 1, 2, and 4, are effective July 1, 2020. Subdivision 3 is effective July 1, 2022.

Sec. 11. **[256.0113] COUNTY HUMAN SERVICES STATE FUNDING REALLOCATION.**

(a) Beginning October 1, 2019, counties and tribes or tribal agencies receiving human services grants funded exclusively with state general fund dollars may allocate any unexpended grant amounts to any county or tribal human services activity for the fourth quarter of the county or tribe's fiscal year.

(b) Any proposed reallocation of unspent funds must be approved by majority vote of the county board or the tribe or tribal agency's governing body.

(c) Each county, tribe, or tribal agency shall report any approved reallocation of unspent grant funds to the commissioner of human services by March 31 of each year following a reallocation under this section. The report shall describe the use of the reallocated human services grant funds, compare how the funds were allocated prior to the reallocation, and explain the advantages or disadvantages of the reallocation.

Sec. 12. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on an on-site review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its

designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment

if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 13. **INFORMATION TECHNOLOGY PROJECTS; PERFORMANCE REQUIREMENT.**

The commissioner of human services shall incorporate measurable indicators of progress toward completion into every information technology project contract. The indicators of progress toward completion must be periodic and at least measure progress for every 25 percent increment toward completion of the project. Every contract must withhold at least ten percent of the total contract amount until the project is complete. The contract must specify that in every instance where an indicator of progress toward completion is not met, a specified proportion of the contract shall be withheld. The minimum amount withheld shall be ten percent of the cumulative amount of the contract up to the date of the failure to meet the indicator of progress toward completion. If an information technology project is not completed on time according to the original contract, the commissioner shall reduce the amount of the contract by ten percent.

Sec. 14. **EVALUATION OF GRANT PROGRAMS; PROVEN-EFFECTIVE PRACTICES.**

(a) The commissioner of management and budget shall consult with the commissioner of human services to establish a plan to review the services delivered under grant programs administered by the commissioner of human services to determine whether the grant programs prioritize proven-effective or promising practices.

(b) In accordance with the plan established in paragraph (a), the commissioner of management and budget, in consultation with the commissioner of human services, shall identify services to evaluate using an experimental or quasi-experimental design to provide information needed to modify or develop grant programs to promote proven-effective practices to improve the intended outcomes of the grant program.

(c) The commissioner of management and budget, in consultation with the commissioner of human services, shall develop reports for the legislature and other stakeholders to provide information on incorporating proven-effective practices in program and budget decisions. The commissioner of management and budget, under Minnesota Statutes, section 15.08, may obtain additional relevant data to support the evaluation activities under this section.

(d) For purposes of this section, the following terms have the meanings given:

(1) "proven-effective practice" means a service or practice that offers a high level of research on effectiveness for at least one outcome of interest, as determined through multiple evaluations outside of Minnesota or one or more local evaluation in Minnesota. The research on effectiveness used to determine whether a service is proven-effective must use rigorously implemented experimental or quasi-experimental designs; and

(2) "promising practices" means a service or practice that is supported by research demonstrating effectiveness for at least one outcome of interest, and includes a single evaluation that is not contradicted by other studies, but does not meet the full criteria for the proven-effective designation. The research on effectiveness used to determine whether a service is a promising practice must use rigorously implemented experimental or quasi-experimental designs.

Sec. 15. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with staff from the House Research Department; House Fiscal Analysis; the Office of Senate Counsel, Research and Fiscal Analysis; and the respective departments shall prepare legislation for introduction in the 2020 legislative session proposing the statutory changes needed to implement the transfers of duties required by Minnesota Statutes, sections 245I.01 and 245I.02.

EFFECTIVE DATE. This section is effective July 1, 2019.

Sec. 16. **REPEALER.**

Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 245G.11, subdivisions 1, 4, and 7, are repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 8

DEPARTMENT OF HUMAN SERVICES; HEALTH CARE

Section 1. Minnesota Statutes 2018, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

Sec. 2. **[254A.21] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.**

(a) The commissioner of human services shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family home visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of human services by February 15 of each year.

Sec. 3. Minnesota Statutes 2018, section 256.9365, is amended to read:

256.9365 PURCHASE OF ~~CONTINUATION~~ HEALTH CARE COVERAGE FOR ~~AIDS PATIENTS~~ PEOPLE LIVING WITH HIV.

Subdivision 1. **Program established.** The commissioner of human services shall establish a program to pay ~~private~~ the cost of health plan premiums and cost sharing for prescriptions, including co-payments, deductibles, and coinsurance for persons who have contracted human immunodeficiency virus (HIV) to enable them to continue coverage under or enroll in a group or individual health plan. If a person is determined to be eligible under subdivision 2, the commissioner shall pay the ~~portion of the group plan premium for which the individual is responsible, if the individual is responsible for at least 50 percent of the cost of the premium, or pay the individual plan premium~~ health insurance premiums and prescription

cost sharing, including co-payments and deductibles required under section 256B.0631. The commissioner shall not pay for that portion of a premium that is attributable to other family members or dependents or is paid by the individual's employer.

Subd. 2. **Eligibility requirements.** To be eligible for the program, an applicant must ~~satisfy the following requirements:~~ meet all eligibility requirements for and enroll in Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009, Public Law 111-87.

~~(1) the applicant must provide a physician's, advanced practice registered nurse's, or physician assistant's statement verifying that the applicant is infected with HIV and is, or within three months is likely to become, too ill to work in the applicant's current employment because of HIV-related disease;~~

~~(2) the applicant's monthly gross family income must not exceed 300 percent of the federal poverty guidelines, after deducting medical expenses and insurance premiums;~~

~~(3) the applicant must not own assets with a combined value of more than $25,000; and~~

~~(4) if applying for payment of group plan premiums, the applicant must be covered by an employer's or former employer's group insurance plan.~~

Subd. 3. **Cost-effective coverage.** Requirements for the payment of individual plan premiums under ~~subdivision 2, clause (5),~~ this section must be designed to ensure that the state cost of paying an individual plan premium does not exceed the estimated state cost that would otherwise be incurred in the medical assistance program. The commissioner shall purchase the most cost-effective coverage available for eligible individuals.

Sec. 4. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2018, section 256B.056, subdivision 1, is amended to read:

Subdivision 1. **Residency.** (a) To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota, in accordance with Code of Federal Regulations, title 42, section 435.403.

(b) The commissioner shall identify individuals who are enrolled in medical assistance and who are absent from the state for more than 30 consecutive days, but who continue to qualify for medical assistance in accordance with paragraph (a).

(c) If the individual is absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota in accordance with paragraph (a), any covered service provided to the individual must be paid through the fee-for-service system and not through the managed care capitated rate payment system under section 256B.69 or 256L.12.

Sec. 6. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) ~~when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision

7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person and the person's spouse in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) Upon initial enrollment, no asset limit shall apply to persons eligible under section 256B.055, subdivision 15. Upon renewal, a person eligible under section 256B.055, subdivision 15, must not own either individually or as a member of a household more than $1,000,000 in assets to continue to be eligible for medical assistance.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2019. Paragraph (b) is effective upon federal approval.

Sec. 7. Minnesota Statutes 2018, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal ~~81~~ 82 percent of the federal poverty guidelines. Effective July 1, 2021, the excess income standard for a person whose eligibility

is based on blindness disability, or age of 65 or more years, is the standard specified in subdivision 4, paragraph (a).

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 8. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual redetermination of eligibility based on information contained in the enrollee's case file and other information available to the agency, including but not limited to information accessed through an electronic database, without requiring the enrollee to submit any information when sufficient data is available for the agency to renew eligibility.

(b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the commissioner must provide the enrollee with a prepopulated renewal form containing eligibility information available to the agency and permit the enrollee to submit the form with any corrections or additional information to the agency and sign the renewal form via any of the modes of submission specified in section 256B.04, subdivision 18.

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter. The local agency may close the enrollee's case file if the required information is not submitted within four months of termination.

(d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be required to renew eligibility every six months.

Sec. 9. Minnesota Statutes 2018, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services in accordance with this subdivision.

(b) Medical assistance dental coverage for ~~nonpregnant adults~~ adults who are eligible under section 256B.055, subdivision 7, is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

~~(d)~~ (a) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

~~(e)~~ (b) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

~~(f)~~ (c) The commissioner shall not require prior authorization for the services included in paragraph ~~(e)~~ (b), clauses (1) to (3), and shall prohibit managed care and county-based purchasing plans from requiring prior authorization for the services included in paragraph ~~(e)~~ (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

Sec. 10. Minnesota Statutes 2018, section 256B.0625, subdivision 12, is amended to read:

Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** (a) Medical assistance covers ~~eyeglasses, dentures, and~~ prosthetic devices if prescribed by a licensed practitioner.

(b) Medical assistance covers vision services, eyeglasses, and dentures for children and adults eligible under section 256B.055, subdivision 7, if prescribed by a licensed practitioner.

Sec. 11. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States

Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective April 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2018, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ~~actual acquisition~~ ingredient costs of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $10.48 for ~~legend prescription drugs, except that~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions ~~which~~ that must be compounded by the pharmacist shall be ~~$8~~ $10.48 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.48 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses

a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug ~~acquired through~~ for a provider participating in the federal 340B Drug Pricing Program shall be ~~estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to~~, but~~ the actual acquisition cost of the drug product and no higher than~~, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs~~ the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a

packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a multisource drug, ~~payment shall be the lower of the usual and customary price charged to the public or~~ the ingredient cost shall be the NADAC of the generic product or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. ~~Effective January 1, 2014,~~ The commissioner shall discount the payment rate for drugs

obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(f) The commissioner may ~~negotiate lower reimbursement~~ establish maximum allowable cost rates for specialty pharmacy products ~~than the rates~~ that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum allowable cost to prevent access to care issues.

(g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a

copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

EFFECTIVE DATE. This section is effective April 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained or denied.

Sec. 13. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.~~

~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 18d, is amended to read:

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

(i) two counties within the 11-county metropolitan area;

(ii) one county representing the rural area of the state; and

(iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) ~~four~~ five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Prescribed pediatric extended care (PPEC) center basic services.** Medical assistance covers PPEC center basic services as defined under section 144H.01, subdivision 2. PPEC basic services shall be reimbursed according to section 256B.86.

EFFECTIVE DATE. This section is effective July 1, 2020, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the commissioner of health and the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2018, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

EFFECTIVE DATE. This section is effective April 1, 2019.

Sec. 17. Minnesota Statutes 2018, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; ~~and~~

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective

basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Sec. 18. Minnesota Statutes 2018, section 256B.69, subdivision 31, is amended to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

(f) The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by $47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 5i.

(g) Beginning January 1, 2020, to December 31, 2024, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2020, 2021, 2023, and 2024:

(1) 3.4 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 3.4 percent for medical assistance special needs basic care;

(3) 2.4 percent for medical assistance families and children; and

(4) 2.4 percent for medical assistance adults without children.

Sec. 19. **[256B.86] PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTER SERVICES.**

Subdivision 1. **Reimbursement rates.** The daily per-child payment rates for PPEC basic services covered by medical assistance and provided at PPEC centers licensed under chapter 144H are:

(1) for intense complexity: $550 for four or more hours and $275 for less than four hours;

(2) for high complexity: $450 for four or more hours and $225 for less than four hours; and

(3) for moderate complexity: $400 for four or more hours and $200 for less than four hours.

Subd. 2. **Determination of complexity level.** Complexity level shall be determined based on the level of nursing intervention required for each child using an assessment tool approved by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2020, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2018, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent for families or individuals with incomes equal to or below 150 percent of the federal poverty guidelines; and to 87 percent for families or individuals with incomes that are above 150 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

Sec. 21. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Minnesota EHB Benchmark Plan.** Notwithstanding subdivisions 1, 2, 3, 3a, and 3b, and section 256L.12, or any other law to the contrary, the services covered for parents, caretakers, foster parents, or legal guardians and single adults without children eligible for MinnesotaCare under section 256L.04 shall be the services covered under the Minnesota EHB Benchmark Plan for plan year 2016 or the actuarial equivalent.

Sec. 22. **CORRECTIVE PLAN TO ELIMINATE DUPLICATE PERSONAL IDENTIFICATION NUMBERS.**

(a) The commissioner of human services shall design and implement a corrective plan to address the issue of medical assistance enrollees being assigned more than one personal identification number. Any corrections or fixes that are necessary to address this issue are required to be completed by June 30, 2021.

(b) By February 15, 2020, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the progress of the corrective plan required in paragraph (a), including an update on meeting the June 30, 2021, deadline. The report must also include information on:

(1) the number of medical assistance enrollees who have been assigned two or more personal identification numbers;

(2) any possible financial effect of enrollees having duplicate personal identification numbers on health care providers and managed care organizations, including the effect on reimbursement rates, meeting withhold requirements, and capitated payments; and

(3) any effect on federal payments received by the state.

Sec. 23. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; QUALITY MEASURES FOR PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTERS.**

(a) The commissioner of human services, in consultation with community stakeholders as defined by the commissioner and PPEC centers licensed prior to June 30, 2024, shall develop quality measures for PPEC centers, procedures for PPEC centers to report quality measures to the commissioner, and methods for the commissioner to make the results of the quality measures available to the public.

(b) The commissioner of human services shall submit by February 1, 2024, a report on the topics described in paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services.

EFFECTIVE DATE. This section is effective upon the effective date of section 13.

Sec. 24. **PAIN MANAGEMENT.**

(a) The Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration of nonpharmacologic pain management that are clinically viable and sustainable; reduce or eliminate chronic pain conditions; improve functional status; and prevent addiction and reduce dependence on opiates or other pain medications. The recommendations must be based on best practices for the effective treatment of musculoskeletal pain provided by health practitioners identified in paragraph (b), and covered under medical assistance. Each health practitioner represented under paragraph (b) shall present the minimum best integrated

practice recommendations, policies, and scientific evidence for nonpharmacologic treatment options for eliminating pain and improving functional status within their full professional scope. Recommendations for integration of services may include guidance regarding screening for co-occurring behavioral health diagnoses; protocols for communication between all providers treating a unique individual, including protocols for follow-up; and universal mechanisms to assess improvements in functional status.

(b) In evaluating and making recommendations, the Health Services Policy Committee shall consult and collaborate with the following health practitioners: acupuncture practitioners licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes, sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, with experience in providing primary care collaboratively within a multidisciplinary team of health care practitioners who employ nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

(c) The commissioner shall submit a progress report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2020, and shall report final recommendations by August 1, 2020. The final report may also contain recommendations for developing and implementing a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and improving functional status.

Sec. 25. **REPEALER.**

Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 256B.0625, subdivision 31c, are repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 9
DEPARTMENT OF HEALTH

Section 1. **[8.40] LITIGATION DEFENSE FUND.**

(a) There is created in the special revenue fund an account entitled the Pain-Capable Unborn Child Protection Act litigation account for the purpose of providing funds to pay

for any costs and expenses incurred by the state attorney general in relation to actions surrounding defense of sections 145.4141 to 145.4147.

(b) The account shall be maintained by the commissioner of management and budget.

(c) The litigation account shall consist of:

(1) appropriations made to the account by the legislature; and

(2) any donations, gifts, or grants made to the account by private citizens or entities.

(d) The litigation account shall retain the interest income derived from the money credited to the account.

(e) Any funds in the litigation account are appropriated to the attorney general for the purposes described in paragraph (a).

Sec. 2. Minnesota Statutes 2018, section 18K.03, is amended to read:

18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.

Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant to this chapter.

Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may sell hemp products derived from industrial hemp grown in this state to medical cannabis manufacturers as authorized under sections 152.22 to 152.37.

Sec. 3. Minnesota Statutes 2018, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** ~~By January 1, 2015, all hospitals and health care providers, as defined in section 62J.03, subdivision 8, must have in place an interoperable electronic health records system within their hospital system or clinical practice setting.~~ The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop ~~a statewide plan to meet this goal, including~~ uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. The commissioner shall include an update on standards development as part of an annual report to the legislature. Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2018, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) ~~To meet the requirements of subdivision 1,~~ Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a state-certified health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. **[62J.84] PRESCRIPTION DRUG PRICE TRANSPARENCY.**

Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price Transparency Act."

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Manufacturer" means a drug manufacturer licensed under section 151.252.

(d) "New prescription drug" means a prescription drug approved for marketing by the United States Food and Drug Administration for which no previous wholesale acquisition cost has been established for comparison.

(e) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(f) "Prescription drug" or "drug" has the meaning provided in section 151.44, paragraph (d).

(g) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning July 1, 2020, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which:

(1) the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days; and

(2) there was a net increase of ten percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information:

(1) the name and price of the drug and the net increase, expressed as a percentage;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years;

(5) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the total sales revenue for the prescription drug during the previous 12-month period;

(7) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

(8) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs, if applicable;

(9) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(10) the patent expiration date of the prescription drug if it is under patent;

(11) the name and location of the company that manufactured the drug; and

(12) the ten highest prices paid for the prescription drug during the previous calendar year in any country other than the United States.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Subd. 4. **New prescription drug price reporting.** (a) Beginning March 15, 2020, no later than 60 days after a manufacturer introduces a new prescription drug for sale in the United States that is a new brand name drug with a price that is greater than $500 for a 30-day supply or a new generic drug with a price that is greater than $200 for a 30-day supply, the manufacturer must submit to the commissioner, in the form and manner prescribed by the commissioner, the following information:

(1) the price of the prescription drug;

(2) whether the Food and Drug Administration granted the new prescription drug a breakthrough therapy designation or a priority review;

(3) the direct costs incurred by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

(4) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning July 1, 2020, for every newly acquired prescription drug for which the price increases by more than $100 for a 30-day supply from the price before the acquisition and the price after the acquisition, the acquiring manufacturer must submit to the commissioner at least 60 days after the acquiring manufacturer begins to sell the newly acquired prescription drug, in the form and manner prescribed by the commissioner, the following information:

(1) the price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;

(2) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;

(3) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;

(4) the price of the prescription drug for the previous five years;

(5) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the manufacturer's drug; and

(6) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, and 5.

(b) The information must be published in an easy to read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section

if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is information that is not already available in the public domain.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate; in issuing the form and format of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

(b) The commissioner may consult with representatives of manufacturers to establish a standard format for reporting information under this section to minimize administrative burdens to the state and manufacturers.

Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil penalty, as provided in paragraph (b), for:

(1) failing to submit timely reports or notices as required by this section;

(2) failing to provide information required under this section; or

(3) providing inaccurate or incomplete information under this section.

(b) The commissioner shall adopt a schedule of civil penalties, not to exceed $10,000 per day of violation, based on the severity of each violation.

(c) The commissioner shall impose civil penalties under this section as provided in section 144.99, subdivision 4.

(d) The commissioner may remit or mitigate civil penalties under this section upon terms and conditions the commissioner considers proper and consistent with public health and safety.

(e) Civil penalties collected under this section shall be deposited in the health care access fund.

Subd. 9. **Legislative report.** (a) No later than January 15 of each year, beginning January 15, 2021, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and human services

policy and finance on the implementation of this section, including, but not limited to, the effectiveness in addressing the following goals:

(1) promoting transparency in pharmaceutical pricing for the state and other payers;

(2) enhancing the understanding on pharmaceutical spending trends; and

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and 5.

Sec. 6. Minnesota Statutes 2018, section 144.057, subdivision 3, is amended to read:

Subd. 3. **Reconsiderations.** The commissioner of health shall review and decide reconsideration requests, including the granting of variances, in accordance with the procedures and criteria contained in chapter 245C. The commissioner must set aside a disqualification for an individual who requests reconsideration and who meets the criteria described in section 245C.22, subdivision 4, paragraph (d). The commissioner's decision shall be provided to the individual and to the Department of Human Services. The commissioner's decision to grant or deny a reconsideration of disqualification is the final administrative agency action, except for the provisions under sections 245C.25, 245C.27, and 245C.28, subdivision 3.

Sec. 7. Minnesota Statutes 2018, section 144.1506, subdivision 2, is amended to read:

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot. For eligible residency programs longer than three years, training grants may be awarded for the duration of the residency, not exceeding an average of $100,000 per residency slot per year.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing an accredited primary care residency program;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits residency programs;

(3) establishing new residency programs or new resident training slots;

(4) recruitment, training, and retention of new residents and faculty;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new primary care resident training slots; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Sec. 8. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 9. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include, but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with health plan company tobacco prevention and cessation services that may be available to individuals depending on their health coverage.

Sec. 10. Minnesota Statutes 2018, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing and monitoring the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section. If the commissioner does not issue a finding within the time limit specified in paragraph (c), the commissioner must return to the applicant the entire amount the applicant paid to the commissioner. For a hospital that is seeking an exception to the moratorium under section 144.551, the plan must be submitted to the commissioner no later than August 1 of the calendar year prior to the year when the exception will be considered by the legislature.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding. If the commissioner determines that additional information is required from the hospital submitting a plan under this section, the commissioner shall notify the hospital of the additional information required no more than 30 days after the initial submission of the plan. A hospital submitting a plan from whom the commissioner has requested additional information shall submit the requested additional information within 14 calendar days of the commissioner's request.

(c) The commissioner shall review the plan and, within ~~90~~ 150 calendar days~~, but no more than six months if extenuating circumstances apply~~ of the initial submission of the plan, issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services given the number of available beds. For the purposes

of this clause, "available beds" means the number of licensed acute care beds that are immediately available for use or could be brought online within 48 hours without significant facility modifications;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

(d) If the plan is being submitted by an existing hospital seeking authority to construct a new hospital, the commissioner shall also consider:

(1) the ability of the applicant to maintain the applicant's current level of community benefit as defined in section 144.699, subdivision 5, at the existing facility; and

(2) the impact on the workforce at the existing facility including the applicant's plan for:

(i) transitioning current workers to the new facility;

(ii) retraining and employment security for current workers; and

(iii) addressing the impact of layoffs at the existing facility on affected workers.

(e) Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

(f) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

(g) If an exception to the moratorium is approved under section 144.551 after a review under this section, the commissioner shall monitor the implementation of the exception up to completion of the construction project. Thirty days after completion of the construction project, the hospital shall submit to the commissioner a report on how the construction has met the provisions of the plan originally submitted under the public interest review process or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

Sec. 11. Minnesota Statutes 2018, section 144.586, is amended by adding a subdivision to read:

Subd. 3. **Care coordination implementation.** (a) This subdivision applies to hospital discharges involving a child with a high-cost medical or chronic condition who needs post-hospital continuing aftercare, including but not limited to home health care services, post-hospital extended care services, or outpatient services for follow-up or ancillary care, or is at risk of recurrent hospitalization or emergency room services due to a medical or chronic condition.

(b) In addition to complying with the discharge planning requirements in subdivision 2, the hospital must ensure that the following conditions are met and arrangements made before discharging any patient described in paragraph (a):

(1) the patient's primary care provider and either the health carrier or, if the patient is enrolled in medical assistance, the managed care organization are notified of the patient's date of anticipated discharge and provided a description of the patient's aftercare needs and a copy of the patient's discharge plan, including any necessary medical information release forms;

(2) the appropriate arrangements for home health care or post-hospital extended care services are made and the initial services as indicated on the discharge plan are scheduled; and

(3) if the patient is eligible for care coordination services through a health plan or health certified medical home, the appropriate care coordinator has connected with the patient's family.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 12. **[144.591] DISCLOSURE OF HOSPITAL CHARGES.**

(a) Each hospital, including hospitals designated as critical access hospitals, shall provide to each discharged patient within 30 calendar days of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may include technical terms to describe the medical services and goods if the technical terms are defined on the itemized description with limited medical nomenclature. The itemized description of billed charges must not describe a billed charge using only a medical billing code, "miscellaneous charges," or "supply charges."

(b) A hospital may not bill or otherwise charge a patient for the itemized description of billed charges.

(c) A hospital must provide an itemized description by secure e-mail, via a secure online portal, or, upon request, by mail.

(d) This section does not apply to patients enrolled in Medicare, medical assistance, the MinnesotaCare program, or who receive health care coverage through an employer self-insured health plan.

EFFECTIVE DATE. This section is effective August 1, 2020.

Sec. 13. **[144.6502] ELECTRONIC MONITORING IN CERTAIN HEALTH CARE FACILITIES.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Electronic monitoring" means the placement and use of an electronic monitoring device by a resident in the resident's room or private living unit in accordance with this section.

(c) "Commissioner" means the commissioner of health.

(d) "Department" means the Department of Health.

(e) "Electronic monitoring device" means a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living unit.

(f) "Facility" means a nursing home licensed under chapter 144A, a boarding care home licensed under sections 144.50 to 144.56, or a housing with services establishment registered under chapter 144D that is either subject to chapter 144G or has a disclosed special unit under section 325F.72.

(g) "Resident" means a person 18 years of age or older residing in a facility.

(h) "Resident representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian;

(2) a health care agent under section 145C.01, subdivision 2; or

(3) a person who is not an agent of a facility or of a home care provider designated in writing by the resident and maintained in the resident's records on file with the facility or with the resident's executed housing with services contract.

Subd. 2. **Electronic monitoring.** (a) A resident or a resident representative may conduct electronic monitoring of the resident's room or private living unit through the use of electronic monitoring devices placed in the resident's room or private living unit as provided in this section.

(b) Nothing in this section precludes the use of electronic monitoring of health care allowed under other law.

(c) Electronic monitoring authorized under this section is not a covered service under home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

(d) This section does not apply to monitoring technology authorized as a home and community-based service under section 256B.0913, 256B.0915, 256B.092, or 256B.49.

Subd. 3. **Consent to electronic monitoring.** (a) Except as otherwise provided in this subdivision, a resident must consent to electronic monitoring in the resident's room or private living unit in writing on a notification and consent form. If the resident has not affirmatively objected to electronic monitoring and the resident's medical professional determines that the resident currently lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the resident representative may consent on behalf of the resident. For purposes of this subdivision, a resident affirmatively objects when the resident orally, visually, or through the use of auxiliary aids or services declines electronic monitoring. The resident's response must be documented on the notification and consent form.

(b) Prior to a resident representative consenting on behalf of a resident, the resident must be asked if the resident wants electronic monitoring to be conducted. The resident representative must explain to the resident:

(1) the type of electronic monitoring device to be used;

(2) the standard conditions that may be placed on the electronic monitoring device's use, including those listed in subdivision 6;

(3) with whom the recording may be shared under subdivision 10 or 11; and

(4) the resident's ability to decline all recording.

(c) A resident, or resident representative when consenting on behalf of the resident, may consent to electronic monitoring with any conditions of the resident's or resident representative's choosing, including the list of standard conditions provided in subdivision 6. A resident, or resident representative when consenting on behalf of the resident, may request that the electronic monitoring device be turned off or the visual or audio recording component of the electronic monitoring device be blocked at any time.

(d) Prior to implementing electronic monitoring, a resident, or resident representative when acting on behalf of the resident, must obtain the written consent on the notification and consent form of any other resident residing in the shared room or shared private living unit. A roommate's or roommate's resident representative's written consent must comply with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's resident representative under this paragraph authorizes the resident's use of any recording obtained under this section, as provided under subdivision 10 or 11.

(e) Any resident conducting electronic monitoring must immediately remove or disable an electronic monitoring device prior to a new roommate moving into a shared room or shared private living unit, unless the resident obtains the roommate's or roommate's resident representative's written consent as provided under paragraph (d) prior to the roommate moving into the shared room or shared private living unit. Upon obtaining the new roommate's signed notification and consent form and submitting the form to the facility as required under subdivision 5, the resident may resume electronic monitoring.

(f) The resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, may withdraw consent at any time and the withdrawal of consent must be documented on the original consent form as provided under subdivision 5, paragraph (c).

Subd. 4. **Refusal of roommate to consent.** If a resident of a facility who is residing in a shared room or shared living unit, or the resident representative of such a resident when acting on behalf of the resident, wants to conduct electronic monitoring and another resident living in or moving into the same shared room or shared living unit refuses to consent to the use of an electronic monitoring device, the facility shall make a reasonable attempt to accommodate the resident who wants to conduct electronic monitoring. A facility has met the requirement to make a reasonable attempt to accommodate a resident or resident representative who wants to conduct electronic monitoring when, upon notification that a roommate has not consented to the use of an electronic monitoring device in the resident's room, the facility offers to move the resident to another shared room or shared living unit that is available at the time of the request. If a resident chooses to reside in a private room

or private living unit in a facility in order to accommodate the use of an electronic monitoring device, the resident must pay either the private room rate in a nursing home setting, or the applicable rent in a housing with services establishment. If a facility is unable to accommodate a resident due to lack of space, the facility must reevaluate the request every two weeks until the request is fulfilled. A facility is not required to provide a private room, a single-bed room, or a private living unit to a resident who is unable to pay.

Subd. 5. **Notice to facility.** (a) Electronic monitoring may begin only after the resident or resident representative who intends to place an electronic monitoring device and any roommate or roommate's resident representative completes the notification and consent form and submits the form to the facility.

(b) Upon receipt of any completed notification and consent form, the facility must place the original form in the resident's file or file the original form with the resident's housing with services contract. The facility must provide a copy to the resident and the resident's roommate, if applicable.

(c) In the event that a resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, chooses to alter the conditions under which consent to electronic monitoring is given or chooses to withdraw consent to electronic monitoring, the facility must make available the original notification and consent form so that it may be updated. Upon receipt of the updated form, the facility must place the updated form in the resident's file or file the original form with the resident's signed housing with services contract. The facility must provide a copy of the updated form to the resident and the resident's roommate, if applicable.

(d) If a new roommate, or the new roommate's resident representative when consenting on behalf of the new roommate, does not submit to the facility a completed notification and consent form and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(e) If a roommate, or the roommate's resident representative when withdrawing consent on behalf of the roommate, submits an updated notification and consent form withdrawing consent and the resident conducting electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(f) Notwithstanding paragraph (a), the resident or resident representative who intends to place an electronic monitoring device may do so without submitting a notification and consent form to the facility, provided that:

(1) the resident or resident representative reasonably fears retaliation by the facility;

(2) the resident does not have a roommate;

(3) the resident or resident representative submits the completed notification and consent form to the Office of the Ombudsman for Long-Term Care;

(4) the resident or resident representative submits the notification and consent form to the facility within seven calendar days of placing the electronic monitoring device; and

(5) the resident or resident representative immediately submits a Minnesota Adult Abuse Reporting Center report or police report upon evidence from the electronic monitoring device that suspected maltreatment has occurred between the time the electronic monitoring device is placed under this paragraph and the time the resident or resident representative submits the completed notification and consent form to the facility.

Subd. 6. **Form requirements.** (a) The notification and consent form completed by the resident must include, at a minimum, the following information:

(1) the resident's signed consent to electronic monitoring or the signature of the resident representative, if applicable. If a person other than the resident signs the consent form, the form must document the following:

(i) the date the resident was asked if the resident wants electronic monitoring to be conducted;

(ii) who was present when the resident was asked;

(iii) an acknowledgment that the resident did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf;

(2) the resident's roommate's signed consent or the signature of the roommate's resident representative, if applicable. If a roommate's resident representative signs the consent form, the form must document the following:

(i) the date the roommate was asked if the roommate wants electronic monitoring to be conducted;

(ii) who was present when the roommate was asked;

(iii) an acknowledgment that the roommate did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf;

(3) the type of electronic monitoring device to be used;

(4) a list of standard conditions or restrictions that the resident or a roommate may elect to place on the use of the electronic monitoring device, including but not limited to:

(i) prohibiting audio recording;

(ii) prohibiting video recording;

(iii) prohibiting broadcasting of audio or video;

(iv) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional;

(v) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while dressing or bathing is performed; and

(vi) turning off the electronic monitoring device for the duration of a visit with a spiritual adviser, ombudsman, attorney, financial planner, intimate partner, or other visitor;

(5) any other condition or restriction elected by the resident or roommate on the use of an electronic monitoring device;

(6) a statement of the circumstances under which a recording may be disseminated under subdivision 10;

(7) a signature box for documenting that the resident or roommate has withdrawn consent; and

(8) an acknowledgment that the resident, in accordance with subdivision 3, consents, authorizes, and allows the Office of Ombudsman for Long-Term Care and representatives of its office to disclose information about the form limited to:

(i) the fact that the form was received from the resident or resident representative;

(ii) if signed by a resident representative, the name of the resident representative and the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf; and

(iii) the type of electronic monitoring device placed.

(b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit.

(c) Notification and consent forms received by the Office of Ombudsman for Long-Term Care are data protected under section 256.9744.

Subd. 7. **Cost and installation.** (a) A resident choosing to conduct electronic monitoring must do so at the resident's own expense, including paying purchase, installation, maintenance, and removal costs.

(b) If a resident chooses to place an electronic monitoring device that uses Internet technology for visual or audio monitoring, the resident may be responsible for contracting with an Internet service provider.

(c) The facility shall make a reasonable attempt to accommodate the resident's installation needs, including allowing access to the facility's public-use Internet or Wi-Fi systems when available for other public uses.

(d) All electronic monitoring device installations and supporting services must be UL-listed.

Subd. 8. **Notice to visitors.** (a) A facility shall post a sign at each facility entrance accessible to visitors that states "Security cameras and audio devices may be present to record persons and activities."

(b) The facility is responsible for installing and maintaining the signage required in this subdivision.

Subd. 9. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a resident's room or private living unit without the permission of the resident or resident representative.

(b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring device or blocks the visual recording component of the electronic monitoring device at the direction of the resident or resident representative, or if consent has been withdrawn.

Subd. 10. **Dissemination of recordings.** (a) No person may access any video or audio recording created through authorized electronic monitoring without the written consent of the resident or resident representative.

(b) Except as required under other law, a recording or copy of a recording made as provided in this section may only be disseminated for the purpose of addressing health, safety, or welfare concerns of a resident or residents.

(c) A person disseminating a recording or copy of a recording made as provided in this section in violation of paragraph (b) may be civilly or criminally liable.

Subd. 11. **Admissibility of evidence.** Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal, or administrative proceeding.

Subd. 12. **Liability.** (a) For the purposes of state law, the mere presence of an electronic monitoring device in a resident's room or private living unit is not a violation of the resident's right to privacy under section 144.651 or 144A.44.

(b) For the purposes of state law, a facility or home care provider is not civilly or criminally liable for the mere disclosure by a resident or a resident representative of a recording.

Subd. 13. **Immunity from liability.** The Office of Ombudsman for Long-Term Care and representatives of the office are immune from liability as provided under section 256.9742, subdivision 2.

Subd. 14. **Resident protections.** (a) A facility must not:

(1) refuse to admit a potential resident or remove a resident because the facility disagrees with the potential resident's or the resident's decisions regarding electronic monitoring, including when the decision is made by a resident representative acting on behalf of the resident;

(2) retaliate or discriminate against any resident for consenting or refusing to consent to electronic monitoring; or

(3) prevent the placement or use of an electronic monitoring device by a resident who has provided the facility or the Office of the Ombudsman for Long-Term Care with notice and consent as required under this section.

(b) Any contractual provision prohibiting, limiting, or otherwise modifying the rights and obligations in this section is contrary to public policy and is void and unenforceable.

Subd. 15. **Employee discipline.** An employee of the facility or of a contractor providing services at the facility, including an arranged home care provider as defined in section 144D.01, subdivision 2a, who is the subject of proposed corrective or disciplinary action based upon evidence obtained by electronic monitoring must be given access to that evidence for purposes of defending against the proposed action. The recording or a copy of the recording must be treated confidentially by the employee and must not be further disseminated to any other person except as required under law. Any copy of the recording

must be returned to the facility or resident who provided the copy when it is no longer needed for purposes of defending against a proposed action.

Subd. 16. **Penalties.** (a) The commissioner may issue a correction order as provided under section 144A.10, 144A.45, or 144A.474, upon a finding that the facility has failed to comply with subdivision 5, paragraphs (b) to (e); 6, paragraph (b); 7, paragraph (c); 8; 9; 10; or 14. For each violation of this section, the commissioner may impose a fine up to $500 upon a finding of noncompliance with a correction order issued according to this subdivision.

(b) The commissioner may exercise the commissioner's authority provided under section 144D.05 to compel a housing with services establishment to meet the requirements of this section.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to all agreements in effect, entered into, or renewed on or after that date.

Sec. 14. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low-incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical

and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

(e) This subdivision expires June 30, ~~2019~~ 2025.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. Minnesota Statutes 2018, section 144H.01, subdivision 5, is amended to read:

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child under ~~21~~ seven years of age who, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision ~~which~~ that must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

Sec. 16. Minnesota Statutes 2018, section 144H.04, subdivision 1, is amended to read:

Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. ~~Effective January 1, 2018,~~ Beginning July 1, 2020, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules that apply to PPEC centers. A license issued under this subdivision is valid for two years.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2018.

Sec. 17. Minnesota Statutes 2018, section 144H.04, is amended by adding a subdivision to read:

Subd. 1a. **Licensure phase-in.** (a) The commissioner shall phase in licensure of PPEC centers by issuing prior to June 30, 2024, no more than two licenses to applicants the

commissioner determines meet the requirements of this chapter. A license issued under this subdivision is valid until June 30, 2024.

(b) This subdivision expires July 1, 2024.

EFFECTIVE DATE. This section is effective upon the effective date of section 12.

Sec. 18. Minnesota Statutes 2018, section 144H.06, is amended to read:

144H.06 APPLICATION OF RULES FOR HOSPICE SERVICES AND RESIDENTIAL HOSPICE FACILITIES.

Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter, except that the following parts, subparts, and items~~, and subitems~~ do not apply:

(1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

(2) Minnesota Rules, part 4664.0008;

(3) Minnesota Rules, part 4664.0010, subparts 3; 4, ~~items A, subitem (6), and~~ item B; and 8;

(4) Minnesota Rules, part 4664.0020, subpart 13;

(5) Minnesota Rules, part 4664.0370, subpart 1;

(6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

(7) Minnesota Rules, part 4664.0420;

(8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

(9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

(10) Minnesota Rules, part 4664.0490; and

(11) Minnesota Rules, part 4664.0520.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 144H.07, subdivision 1, is amended to read:

Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex or technologically dependent children, based on a protocol of care established for each child. A PPEC center may provide services up to ~~14~~ 12.5 hours a day and up to six days a week with hours of operation during normal waking hours.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 144H.07, subdivision 2, is amended to read:

Subd. 2. **Limitations.** A PPEC center must comply with the following standards related to services:

(1) a child is prohibited from attending a PPEC center for more than ~~14~~ 12.5 hours within a 24-hour period;

(2) a PPEC center is prohibited from providing services other than those provided to medically complex or technologically dependent children; and

(3) the maximum capacity for medically complex or technologically dependent children at a center shall not exceed 45 children.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 144H.08, subdivision 2, is amended to read:

Subd. 2. ~~**Duties of administrator**~~ **Administrators.** (a) The center administrator is responsible and accountable for overall management of the center. The administrator must:

(1) designate in writing a person to be responsible for the center when the administrator is absent from the center for more than 24 hours;

(2) maintain the following written records, in a place and form and using a system that allows for inspection of the records by the commissioner during normal business hours:

(i) a daily census record, which indicates the number of children currently receiving services at the center;

(ii) a record of all accidents or unusual incidents involving any child or staff member that caused, or had the potential to cause, injury or harm to a person at the center or to center property;

(iii) copies of all current agreements with providers of supportive services or contracted services;

(iv) copies of all current agreements with consultants employed by the center, documentation of each consultant's visits, and written, dated reports; and

(v) a personnel record for each employee, which must include an application for employment, references, employment history for the preceding five years, and copies of all performance evaluations;

(3) develop and maintain a current job description for each employee;

(4) provide necessary qualified personnel and ancillary services to ensure the health, safety, and proper care for each child; and

(5) develop and implement infection control policies that comply with rules adopted by the commissioner regarding infection control.

(b) In order to serve as an administrator of a PPEC center, an individual must have at least two years of experience in the past five years caring for or managing the care of medically complex or technologically dependent individuals.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 22. Minnesota Statutes 2018, section 144H.11, subdivision 2, is amended to read:

Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a registered nurse licensed in Minnesota, and hold a current certification in cardiopulmonary resuscitation~~, and have experience in the previous 24 months in being responsible for the care of acutely ill or chronically ill children~~.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 23. Minnesota Statutes 2018, section 144H.11, subdivision 3, is amended to read:

Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC center must be supervised by a registered nurse and must be a licensed practical nurse licensed in Minnesota, ~~have at least two years of experience in pediatrics,~~ and hold a current certification in cardiopulmonary resuscitation.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 24. Minnesota Statutes 2018, section 144H.11, subdivision 4, is amended to read:

Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this subdivision may include nursing assistants ~~and~~ or individuals with training and experience in the field of education, social services, or child care.

(b) All direct care personnel employed by a PPEC center must work under the supervision of a registered nurse and are responsible for providing direct care to children at the center. Direct care personnel must have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 25. Minnesota Statutes 2018, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(11) the medical specialty of the physician performing the abortion;

(12) if the abortion was performed via telemedicine, the facility code for the patient and the facility code for the physician; ~~and~~

(13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known~~.~~;

(14) whether a determination of probable postfertilization age was made and the probable postfertilization age determined, including:

(i) the method used to make such a determination; or

(ii) if a determination was not made prior to performing an abortion, the basis of the determination that a medical emergency existed; and

(15) for abortions performed after a determination of postfertilization age of 20 or more weeks, the basis of the determination that the pregnant woman had a condition that so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.

Sec. 26. **[145.4141] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 145.4141 to 145.4147, the following terms have the meanings given them.

Subd. 2. **Abortion.** "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant, with an intention other than to increase the probability of a live birth; to preserve the life or health of the child after live birth; or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and which causes the premature termination of the pregnancy.

Subd. 3. **Attempt to perform or induce an abortion.** "Attempt to perform or induce an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of sections 145.4141 to 145.4147.

Subd. 4. **Fertilization.** "Fertilization" means the fusion of a human spermatozoon with a human ovum.

Subd. 5. **Medical emergency.** "Medical emergency" means a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that it necessitates the immediate abortion of her pregnancy without first determining postfertilization age to avert her death or for which the delay necessary to determine postfertilization age will create serious risk of substantial and irreversible physical impairment of a major bodily function not including psychological or emotional conditions. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Subd. 6. **Physician.** "Physician" means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state.

Subd. 7. **Postfertilization age.** "Postfertilization age" means the age of the unborn child as calculated from the fusion of a human spermatozoon with a human ovum.

Subd. 8. **Probable postfertilization age of the unborn child.** "Probable postfertilization age of the unborn child" means what, in reasonable medical judgment, will with reasonable probability be the postfertilization age of the unborn child at the time the abortion is planned to be performed or induced.

Subd. 9. **Reasonable medical judgment.** "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

Subd. 10. **Unborn child or fetus.** "Unborn child" or "fetus" means an individual organism of the species homo sapiens from fertilization until live birth.

Subd. 11. **Woman.** "Woman" means a female human being whether or not she has reached the age of majority.

Sec. 27. **[145.4142] LEGISLATIVE FINDINGS.**

(a) The legislature makes the following findings.

(b) Pain receptors (nociceptors) are present throughout an unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by 20 weeks.

(c) By eight weeks after fertilization, an unborn child reacts to touch. After 20 weeks an unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example by recoiling.

(d) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.

(e) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life.

(f) For the purposes of surgery on an unborn child, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to the level when painful stimuli is applied without anesthesia.

(g) The position, asserted by some medical experts, that an unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex.

However, recent medical research and analysis, especially since 2007, provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

(h) Substantial evidence indicates that children born missing the bulk of the cerebral cortex, those with hydranencephaly, nevertheless experience pain.

(i) In adults, stimulation or ablation of the cerebral cortex does not alter pain perception, while stimulation or ablation of the thalamus does.

(j) Substantial evidence indicates that structures used for pain processing in early development differ from those of adults, using different neural elements available at specific times during development, such as the subcortical plate, to fulfill the role of pain processing.

(k) The position asserted by some medical experts, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from thrashing about in reaction to invasive surgery.

(l) Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain by 20 weeks after fertilization.

(m) It is the purpose of the state to assert a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain.

Sec. 28. **[145.4143] DETERMINATION OF POSTFERTILIZATION AGE.**

Subdivision 1. **Determination of postfertilization age.** Except in the case of a medical emergency, no abortion shall be performed or induced or be attempted to be performed or induced unless the physician performing or inducing it has first made a determination of the probable postfertilization age of the unborn child or relied upon such a determination made by another physician. In making such a determination, the physician shall make those inquiries of the woman and perform or cause to be performed those medical examinations and tests that a reasonably prudent physician, knowledgeable about the case and the medical conditions involved, would consider necessary to perform in making an accurate diagnosis with respect to postfertilization age.

Subd. 2. **Unprofessional conduct.** Failure by any physician to conform to any requirement of this section constitutes unprofessional conduct under section 147.091, subdivision 1, paragraph (k).

Sec. 29. **[145.4144] ABORTION OF UNBORN CHILD OF 20 OR MORE WEEKS POSTFERTILIZATION AGE PROHIBITED; CAPABLE OF FEELING PAIN.**

Subdivision 1. **Abortion prohibition; exemption.** No person shall perform or induce or attempt to perform or induce an abortion upon a woman when it has been determined, by the physician performing or inducing or attempting to perform or induce the abortion, or by another physician upon whose determination that physician relies, that the probable postfertilization age of the woman's unborn child is 20 or more weeks unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Subd. 2. **When abortion not prohibited.** When an abortion upon a woman whose unborn child has been determined to have a probable postfertilization age of 20 or more weeks is not prohibited by this section, the physician shall terminate the pregnancy in the manner which, in reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the woman than would other available methods. No such greater risk shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Sec. 30. **[145.4145] ENFORCEMENT.**

Subdivision 1. **Criminal penalties.** A person who intentionally or recklessly performs or induces or attempts to perform or induce an abortion in violation of sections 145.4141 to 145.4147 shall be guilty of a felony. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

Subd. 2. **Civil remedies.** (a) A woman upon whom an abortion has been performed or induced in violation of sections 145.4141 to 145.4147, or the father of the unborn child who was the subject of such an abortion, may maintain an action against the person who performed or induced the abortion in intentional or reckless violation of sections 145.4141 to 145.4147

for damages. A woman upon whom an abortion has been attempted in violation of sections 145.4141 to 145.4147 may maintain an action against the person who attempted to perform or induce the abortion in an intentional or reckless violation of sections 145.4141 to 145.4147 for damages.

(b) A cause of action for injunctive relief against a person who has intentionally violated sections 145.4141 to 145.4147 may be maintained by the woman upon whom an abortion was performed or induced or attempted to be performed or induced in violation of sections 145.4141 to 145.4147; by a person who is the father of the unborn child subject to an abortion, parent, sibling, or guardian of, or a current or former licensed health care provider of, the woman upon whom an abortion has been performed or induced or attempted to be performed or induced in violation of sections 145.4141 to 145.4147; by a county attorney with appropriate jurisdiction; or by the attorney general. The injunction shall prevent the abortion provider from performing or inducing or attempting to perform or induce further abortions in this state in violation of sections 145.4141 to 145.4147.

(c) If judgment is rendered in favor of the plaintiff in an action described in this section, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

(d) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

(e) No damages or attorney fees may be assessed against the woman upon whom an abortion was performed or induced or attempted to be performed or induced except according to paragraph (d).

Sec. 31. **[145.4146] PROTECTION OF PRIVACY IN COURT PROCEEDINGS.**

In every civil or criminal proceeding or action brought under the Pain-Capable Unborn Child Protection Act, the court shall rule on whether the anonymity of a woman upon whom an abortion has been performed or induced or attempted to be performed or induced shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each such order shall be accompanied by specific written findings explaining why the anonymity of the woman should be preserved from public disclosure, why the order is essential to that

end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the woman upon whom an abortion has been performed or induced or attempted to be performed or induced, anyone, other than a public official, who brings an action under section 145.4145, subdivision 2, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant or from attorneys for the defendant.

Sec. 32. **[145.4147] SEVERABILITY.**

If any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of sections 145.4141 to 145.4146, or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4141 to 145.4146 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4141 to 145.4146, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of sections 145.4141 to 145.4146, or the application of sections 145.4141 to 145.4146, would be declared unconstitutional.

Sec. 33. Minnesota Statutes 2018, section 145.4235, subdivision 2, is amended to read:

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence ~~for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011~~ for at least two years prior to the date the agency or organization submits an application to the commissioner for a grant under this section.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this section

unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) The commissioner shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information is medically accurate.

Sec. 34. Minnesota Statutes 2018, section 145.4242, is amended to read:

145.4242 INFORMED CONSENT.

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed;

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored website, and what the website address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the website, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), item (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

(c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly incompatible with life must be informed of available perinatal hospice services and offered this care as an alternative to abortion. If perinatal hospice services are declined, voluntary and informed consent by the female seeking an abortion is given if the female receives the information required in paragraphs (a), clause (1), and (b). The female must comply with the requirements in paragraph (a), clauses (3) and (4).

(d) If, at any time prior to the performance of an abortion, a female undergoes an ultrasound examination, or a physician determines that ultrasound imaging will be used during the course of a patient's abortion, the physician or the physician's agent shall orally inform the patient of the opportunity to view or decline to view an active ultrasound image of the unborn child.

Sec. 35. Minnesota Statutes 2018, section 145.4244, is amended to read:

145.4244 INTERNET WEBSITE.

(a) The commissioner of health shall develop and maintain a stable Internet website to provide the information described under section 145.4243. No information regarding who uses the website shall be collected or maintained. The commissioner of health shall monitor the website on a weekly basis to prevent and correct tampering.

(b) A health care facility performing abortions must provide the information described in section 145.4243 on the facility's website or provide a link to the Department of Health website where this information may be viewed.

Sec. 36. Minnesota Statutes 2018, section 145.908, subdivision 1, is amended to read:

Subdivision 1. **Grant program established.** Within the limits of ~~federal funds~~ available ~~specifically~~ appropriations for this purpose, the commissioner of health shall establish a grant program to provide culturally competent programs to screen and treat pregnant women and women who have given birth in the preceding 12 months for pre- and postpartum mood and anxiety disorders. Organizations may use grant funds to establish new screening or treatment programs, or expand or maintain existing screening or treatment programs. In establishing the grant program, the commissioner shall prioritize expanding or enhancing screening for pre- and postpartum mood and anxiety disorders in primary care settings. The commissioner shall determine the types of organizations eligible for grants.

Sec. 37. Minnesota Statutes 2018, section 145.928, subdivision 1, is amended to read:

Subdivision 1. **Goal; establishment.** It is the goal of the state~~, by 2010,~~ to decrease ~~by 50 percent~~ the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Sec. 38. Minnesota Statutes 2018, section 145.928, subdivision 7, is amended to read:

Subd. 7. **Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or ~~both~~ more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; ~~or~~

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

~~(2)~~ (3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or ~~both~~ more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact ~~both~~ two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Sec. 39. Minnesota Statutes 2018, section 145.986, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the ~~top three~~ leading preventable causes of illness and death~~: tobacco use and exposure, poor diet, and lack of regular physical activity~~ as determined by the commissioner through the statewide health assessment;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Sec. 40. Minnesota Statutes 2018, section 145.986, subdivision 1a, is amended to read:

Subd. 1a. **Grants to local communities.** (a) ~~Beginning July 1, 2009,~~ The commissioner of health shall award competitive grants to community health boards and tribal governments to convene, coordinate, and implement ~~evidence-based~~ proven-effective strategies ~~targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco~~, and promising practices or activities that can be evaluated using experimental or quasi-experimental design. Grants shall be awarded to all community health boards and tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, work site, and health care settings;

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

(f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

(g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a

corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) ~~Beginning November 1, 2015, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to implement health improvement strategies that improve the health status, delay the expression of dementia, or slow the progression of dementia, for a targeted population at risk for dementia and shall award at least two of the grants awarded on November 1, 2015, for these purposes. The grants must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services, the Minnesota Board on Aging, and community-based organizations with a focus on dementia. Each grant must include selected outcomes and evaluation measures related to the incidence or progression of dementia among the targeted population using the procedure described in subdivision 2.~~ For purposes of this subdivision, "proven-effective strategy" means a strategy or practice that offers a high level of research on effectiveness for at least one outcome of interest; and "promising practice or activity" means a practice or activity that is supported by research demonstrating effectiveness for at least one outcome of interest.

~~(i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to confront the opioid addiction and overdose epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for these purposes. The grants awarded under this paragraph must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services. Each grant shall include selected outcomes and evaluation measures related to addressing the opioid epidemic.~~

Sec. 41. Minnesota Statutes 2018, section 145.986, subdivision 4, is amended to read:

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program grants funded under this section. The evaluation must use the most appropriate experimental or quasi-experimental design suitable for the grant activity or project. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation, including information on any impact on the health indicators listed in section 62U.10, subdivision 6, within the geographic area or among the population targeted.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems. The commissioner shall consult with the commissioner of management and budget to ensure that the evaluation process is using experimental or quasi-experimental design.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

(e) For purposes of this subdivision, "experimental design" means a method of evaluating the impact of a strategy that uses random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated; and "quasi-experimental design" means a method of evaluating the impact of a strategy that uses an approach other than random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated.

Sec. 42. Minnesota Statutes 2018, section 145.986, subdivision 5, is amended to read:

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. The report must include information on each grant recipient, including the activities that were conducted by the grantee using grant funds, the grantee's progress toward achieving the measurable outcomes established under subdivision 2, and the data provided to the commissioner by the grantee to measure these outcomes for grant activities. The commissioner shall provide information on grants in which a corrective action plan was required under subdivision 1a, the types of plan action, and the progress that has been made toward meeting the measurable outcomes. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. ~~In the report due on January 15, 2014,~~ In the reports due beginning

January 15, 2020, the commissioner shall include a description of the contracts awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were designed and implemented under these contracts.

Sec. 43. Minnesota Statutes 2018, section 145.986, subdivision 6, is amended to read:

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs ~~that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~, or replace discontinued state or federal funds ~~previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~. Funds must not be used to supplant current state or local funding to community health boards or tribal governments ~~used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use~~.

Sec. 44. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5a. **Hemp.** "Hemp" means industrial hemp as defined in section 18K.02, subdivision 3.

Sec. 45. Minnesota Statutes 2018, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil but which does not require the use of dried leaves or plant form; or

(4) any other method, excluding smoking, approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp

grower licensed under chapter 18K as permitted under section 152.29, subdivision 1, paragraph (b).

Sec. 46. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force on medical cannabis therapeutic research and to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, public safety, judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions regarding the use of medical cannabis and hemp; and (2) the market demand and supply in this state for hemp products that can be used for medicinal purposes.

(b) The commissioner may submit medical research based on the data collected under sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a qualifying medical condition.

Sec. 47. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;

(3) advise patients, registered designated caregivers, and parents or legal guardians who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

(4) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

(5) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

~~(c)~~ (d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 48. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~ eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. ~~A manufacturer is required to begin distribution of medical cannabis from at least one distribution facility by July 1, 2015. All distribution facilities must be operational and begin distribution of medical cannabis by July 1, 2016. The distribution facilities shall be located~~ The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. ~~A manufacturer shall disclose the proposed locations for the distribution facilities to the commissioner during the registration process.~~ A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. ~~Any~~ This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and

medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at ~~an additional~~ the other distribution facility ~~site~~ sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may obtain hemp from a hemp grower licensed with the commissioner of agriculture under chapter 18K if the hemp was grown in this state. A manufacturer may use hemp for the purpose of making it available in a form allowable under section 152.22, subdivision 6. Any hemp acquired by a manufacturer under this paragraph is subject to the same quality control program, security and testing requirements, and any other requirement for medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

~~(c)~~ (d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping; ~~and~~

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis~~.~~ ; and

(3) procedures for the delivery and transportation of hemp between hemp growers licensed under chapter 18K and manufacturers.

~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

~~(i)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

~~(j)~~ (k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

~~(k)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp, the manufacturer must verify that the person from whom the manufacturer is acquiring hemp has a valid license issued by the commissioner of agriculture under chapter 18K.

Sec. 49. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall provide a reliable and ongoing supply of all medical cannabis needed for the registry program.

(b) All cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis or manufacturing, packaging, or processing of hemp acquired by the manufacturer must take place in an enclosed, locked facility at a physical address provided to the commissioner during the registration process.

(c) A manufacturer must process and prepare any medical cannabis plant material into a form allowable under section 152.22, subdivision 6, prior to distribution of any medical cannabis.

Sec. 50. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient.

(b) A manufacturer may dispense medical cannabis products, whether or not the products have been manufactured by the manufacturer, but is not required to dispense medical cannabis products.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent or legal guardian listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely using a videoconference, so long as the employee providing the consultation is able to confirm the identity of the patient, the consultation occurs while the patient is at a distribution facility, and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility to carry identification showing that the person is an employee of the manufacturer.

Sec. 51. Minnesota Statutes 2018, section 152.29, subdivision 3a, is amended to read:

Subd. 3a. **Transportation of medical cannabis; staffing.** (a) A medical cannabis manufacturer may staff a transport motor vehicle with only one employee if the medical cannabis manufacturer is transporting medical cannabis to either a certified laboratory for the purpose of testing or a facility for the purpose of disposal. If the medical cannabis manufacturer is transporting medical cannabis for any other purpose or destination, the transport motor vehicle must be staffed with a minimum of two employees as required by rules adopted by the commissioner.

(b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only transporting hemp for any purpose may staff the transport motor vehicle with only one employee.

Sec. 52. Minnesota Statutes 2018, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing information, inspection, and compliance related to hemp growers under chapter 18K.

Sec. 53. Minnesota Statutes 2018, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) weddings, fellowship meals, or funerals conducted by a faith-based organization using any building constructed and primarily used for religious worship or education;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal, sportsman, or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to, affiliated with, or supported by such fraternal, sportsman, or patriotic organizations for events held in the building or on the grounds of the organization and at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen;

(9) a home school in which a child is provided instruction at home;

(10) school concession stands serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626;

(11) group residential facilities of ten or fewer beds licensed by the commissioner of human services under Minnesota Rules, chapter 2960, provided the facility employs or contracts with a certified food manager under Minnesota Rules, part 4626.2015;

(12) food served at fund-raisers or community events conducted in the building or on the grounds of a faith-based organization, provided that a certified food manager, or a volunteer trained in a food safety course, trains the food preparation workers in safe food handling practices. This exemption does not apply to faith-based organizations at the state agricultural society or county fairs or to faith-based organizations that choose to apply for a license;

(13) food service events conducted following a disaster for purposes of feeding disaster relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626; ~~and~~

(14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a community-based nonprofit organization, provided:

(i) the municipality where the event is located approves the event;

(ii) the sponsoring organization must develop food safety rules and ensure that participants follow these rules; and

(iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign or placard must be posted that states: "These products are homemade and not subject to state inspection."

Foods exempt under this clause must be labeled to accurately reflect the name and address of the person preparing the foods~~.~~; and

(15) a special event food stand or a seasonal temporary food stand provided:

(i) the stand is operated solely by a person or persons under the age of 14;

(ii) the stand is located on private property with the permission of the property owner;

(iii) the stand has gross receipts or contributions of $1,000 or less in a calendar year; and

(iv) the operator of the stand posts a sign or placard at the site that states "The products sold at this stand are not subject to state inspection or regulation.", if the stand offers for sale potentially hazardous food as defined in Minnesota Rules, part 4626.0020, subdivision 62.

Sec. 54. **DIRECTION TO THE COMMISSIONER OF HEALTH.**

The commissioner of health shall prescribe the notification and consent form described in Minnesota Statutes, section 144.6502, subdivision 6, no later than January 1, 2020. The commissioner shall make the form available on the department's website.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 55. **PERINATAL HOSPICE GRANTS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Eligible program entity" means a hospital, hospice, health care facility, or community-based organization. An eligible program entity must have a perinatal hospice program coordinator who is eligible to be certified in perinatal loss care.

(c) "Eligible training entity" means an eligible program entity that has experience providing perinatal hospice services, or a qualified individual who is eligible to be certified in perinatal loss care and has experience providing perinatal hospice services.

(d) "Eligible to be certified in perinatal loss care" means an individual who meets the criteria to sit for the perinatal loss care exam, or is already certified in perinatal loss care, by the Hospice and Palliative Credentialing Center.

(e) "Life-limiting prenatal diagnosis" means a fetal condition diagnosed before birth that will with reasonable certainty result in the death of the child within six months after birth.

(f) "Perinatal hospice" means comprehensive support to the pregnant woman and her family that includes family-centered multidisciplinary care to meet their medical, spiritual, and emotional needs from the time of a life-limiting prenatal diagnosis through the birth, life, and natural death of the child, and through the postpartum period. Supportive care may be provided by medical staff, counselors, clergy, mental health providers, social workers, geneticists, certified nurse midwives, hospice professionals, and others.

Subd. 2. **Perinatal hospice development grants.** Perinatal hospice development grants are available to eligible program entities and must be used for expenditures to:

(1) establish a new perinatal hospice program;

(2) expand an existing perinatal hospice program;

(3) recruit a perinatal hospice program coordinator; or

(4) fund perinatal hospice administrative and coordinator expenses for a period of not more than six months.

Subd. 3. **Perinatal hospice training grants.** Perinatal hospice training grants are available to eligible training entities and may be used for expenses to enable existing perinatal hospice programs to provide training for members of a multidisciplinary team providing perinatal hospice services. Funds must be used for:

(1) development and operation of a perinatal hospice training program. The curriculum must include but is not limited to training to provide the following services to families eligible for perinatal hospice:

(i) counseling at the time of a life-limiting prenatal diagnosis;

(ii) specialized birth planning;

(iii) specialized advance care planning;

(iv) services to address the emotional needs of the family through prenatal and postpartum counseling that:

(A) helps the family prepare for the death of their child;

(B) helps the family work within the health care delivery system to create a safe and professionally supported environment where parents can parent their child during their brief life in a way that is meaningful for that family and baby; and

(C) helps the family with the grief that begins at diagnosis and continues after the death of the child; and

(v) evidence-based perinatal bereavement care;

(2) trainer support, including travel expenses and reasonable living expenses during the period of training;

(3) trainee support, including tuition, books, travel expenses, program fees, and reasonable living expenses during the period of training; or

(4) materials used in the provision of training.

Subd. 4. **Perinatal hospice awareness grants.** Perinatal hospice awareness grants are available to eligible program entities and may be used for the creation and distribution of materials promoting awareness of perinatal hospice programs.

Subd. 5. **Report.** The commissioner of health shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by February 1, 2023, on how the grant funds have been used.

Sec. 56. **PLAN FOR A WORKING GROUP ON LINKS BETWEEN HEALTH DISPARITIES AND EDUCATIONAL ACHIEVEMENT FOR CHILDREN FROM AMERICAN INDIAN COMMUNITIES AND COMMUNITIES OF COLOR.**

(a) The commissioner of health, in consultation with the commissioner of education, shall develop a plan to convene one or more working groups to:

(1) examine the links between health disparities and disparities in educational achievement for children from American Indian communities and communities of color; and

(2) develop recommendations for programs, services, or funding to address health disparities and decrease disparities in educational achievement for children from American Indian communities and communities of color.

(b) The plan shall include the possible membership of the proposed working group and the duties for the proposed working group.

(c) The commissioner shall submit the plan for the working group, including proposed legislation establishing the working group, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and education by February 15, 2020.

Sec. 57. **SALE OF CERTAIN CANNABINOID PRODUCTS WORKGROUP.**

(a) The commissioner of health, in consultation with the commissioners of commerce, agriculture, and public safety, and the executive director of the Board of Pharmacy, shall convene a workgroup to advise the legislature on how to regulate products that contain cannabinoids extracted from hemp. For purposes of this section, "hemp" has the meaning given to "industrial hemp" in Minnesota Statutes, section 18K.02, subdivision 3.

(b) The commissioner shall assess the public health and consumer safety impact on the sale of cannabinoids derived from hemp and shall develop a regulatory framework of what the legislature would need to consider including, but not limited to:

(1) cultivation standards for industrial hemp if the hemp is used for any product intended for human or animal consumption;

(2) labeling requirements for products containing cannabidoil extracted from hemp, including the amount and percentage of cannabidiol in the product, the name of the manufacturer of the product, and the ingredients contained in the product;

(3) possible restrictions of advertising and marketing of the cannabidiol product;

(4) restrictions of false, misleading, or unsubstantiated health claims;

(5) requirements for the independent testing of cannabidiol products, including quality control and chemical identification;

(6) safety standards for edible products containing cannabinoids extracted from hemp, including container and packaging requirements; and

(7) any other requirement or procedure the commissioner deems necessary.

(c) By January 15, 2020, the commissioner of health shall submit the results of the workgroup to the chairs and ranking minority members of the legislative committees with jurisdiction over public health, consumer protection, public safety, and agriculture.

Sec. 58. **SHORT TITLE.**

Minnesota Statutes, sections 145.4141 to 145.4147 may be cited as the "Pain-Capable Unborn Child Protection Act."

Sec. 59. **STUDY ON BREASTFEEDING DISPARITIES; STAKEHOLDER ENGAGEMENT.**

(a) The commissioner of health shall work with community stakeholders in Minnesota including but not limited to representatives from the Minnesota Breastfeeding Coalition; Academy of Lactation Policy and Practice; International Board of Lactation Consultant Examiners; DONA International; HealthConnect; Reaching Sisters Everywhere; the La Leche League; the women, infants, and children program; hospitals and clinics; local public health professionals and organizations; community-based organizations; and representatives of populations with low breastfeeding rates to carry out a study to identify barriers, challenges, and successes affecting the initiation, duration, and exclusivity of breastfeeding.

(b) The study must address policy, systemic, and environmental factors that both support and create barriers to breastfeeding. The study must also identify and make recommendations regarding culturally appropriate practices that have been shown to increase breastfeeding rates in populations that have the greatest breastfeeding disparity rates.

(c) The commissioner shall submit a report on the study with any recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on or before September 15, 2020.

Sec. 60. **TRANSITION TO AUTHORIZED ELECTRONIC MONITORING IN CERTAIN HEALTH CARE FACILITIES.**

Any resident, resident representative, or other person conducting electronic monitoring in a resident's room or private living unit prior to January 1, 2020, must comply with the requirements of Minnesota Statutes, section 144.6502, by January 1, 2020.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 61. **REPEALER.**

Minnesota Statutes 2018, sections 144.1464; and 144.1911, are repealed.

ARTICLE 10
MNSURE

Section 1. Minnesota Statutes 2018, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** ~~(a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount~~

~~collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(c)~~ (a) Beginning January 1, 2016, through December 31, 2019, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.~~

(b) Beginning January 1, 2020, MNsure shall retain or collect up to two percent of total premiums for individual and small group health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(e)~~ (c) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

(d) Interagency agreements between MNsure and the Department of Human Services, and the Public Assistance Cost Allocation Plan for the Department of Human Services, shall not be modified to reflect any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section, and no additional funding shall be transferred from the Department of Human Services to MNsure as a result of any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section.

Sec. 2. Minnesota Statutes 2018, section 62V.05, subdivision 5, is amended to read:

Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and

health plans to be offered through MNsure that satisfy federal requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

(1) apply uniformly to all health carriers and health plans in the individual market;

(2) apply uniformly to all health carriers and health plans in the small group market; and

(3) satisfy minimum federal certification requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(c) In accordance with ~~section 1311(e) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e), the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under ~~section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e)(1)(B). ~~The board may consider:~~

~~(1) affordability;~~

~~(2) quality and value of health plans;~~

~~(3) promotion of prevention and wellness;~~

~~(4) promotion of initiatives to reduce health disparities;~~

~~(5) market stability and adverse selection;~~

~~(6) meaningful choices and access;~~

~~(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and~~

~~(8) other criteria that the board determines appropriate.~~

(e) A health plan that meets the minimum certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section, is deemed to be in the interest of qualified individuals and qualified employers. The board shall not establish certification requirements for health carriers and health plans for participation in MNsure that are in addition to the certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section. The board shall not determine the cost of, cost-sharing elements of, or benefits provided in health plans sold through MNsure.

~~(e)~~ (f) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

~~(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.~~

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by

the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Sec. 3. Minnesota Statutes 2018, section 62V.05, subdivision 10, is amended to read:

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

(c) The commissioner of human services shall not bear insurance risk or enter into any agreement with providers to pay claims for any health coverage administered by the commissioner that is made available for purchase through the MNsure website as a qualifying health plan or as an alternative to purchasing a qualifying health plan through MNsure or an individual health plan offered outside of MNsure.

(d) Nothing in this subdivision shall prohibit:

(1) the commissioner of human services from administering the medical assistance program under chapter 256B and the MinnesotaCare program under chapter 256L, as long as health coverage under these programs is not purchased by the individual through the MNsure Web site; and

(2) employees of the Department of Human Services from obtaining insurance from the state employee group insurance program.

Sec. 4. Minnesota Statutes 2018, section 62V.08, is amended to read:

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, and each January 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of data practices laws or procedures; and (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.

(b) MNsure must publish its administrative and operational costs on a website to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue

received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The website must be updated at least annually.

(c) As part of the report required to be submitted to the legislature in paragraph (a), and the information required to be published in paragraph (b), MNsure shall include the total amount spent on business continuity planning, data privacy protection, and cyber security provisions.

Sec. 5. Laws 2015, chapter 71, article 12, section 8, is amended to read:

Sec. 8. **EXPANDED ACCESS TO QUALIFIED HEALTH PLANS AND SUBSIDIES.**

The commissioner of commerce, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies and to allow eligible individuals to receive advanced premium tax credits and cost-sharing reductions when purchasing these health plans. The commissioner shall seek all federal waivers and approvals necessary to implement this proposal and shall submit the necessary federal waivers and approvals to the federal government no later than October 1, 2019. The commissioner shall submit a draft proposal to the MNsure board and the MNsure Legislative Oversight Committee ~~at least 30 days before submitting a final proposal to the federal government~~ no later than September 1, 2019, and shall notify the board and legislative oversight committee of any federal decision or action related to the proposal.

Sec. 6. **MNSURE PROGRAM DEVELOPMENT.**

No funds shall be appropriated to the Board of Directors of MNsure for new program development until 834 EDI transmissions are being processed automatically and are conveying accurate information without the intervention of manual reviews and processes.

Sec. 7. **RATES FOR INDIVIDUAL MARKET HEALTH AND DENTAL PLANS FOR 2020.**

(a) Health carriers must take into account the reduction in the premium withhold percentage under Minnesota Statutes, section 62V.05, subdivision 2, applicable beginning in calendar year 2020 for individual market health plans and dental plans sold through

MNsure when setting rates for individual market health plans and dental plans for calendar year 2020.

(b) For purposes of this section, "dental plan," "health carrier," "health plan," and "individual market" have the meanings given in Minnesota Statutes, section 62V.02.

Sec. 8. **REQUEST FOR INFORMATION ON A PRIVATIZED STATE-BASED MARKETPLACE SYSTEM.**

(a) The commissioner of human services, in consultation with the commissioners of commerce and health, and interested stakeholders, shall develop a request for information to consider the feasibility for a private vendor to provide the technology functionality for the individual market currently provided by MNsure. The request shall seek options for a privately run automated web-based broker system that provides certain core functions including eligibility and enrollment functions, consumer outreach and assistance, and the ability for consumers to compare and choose different qualified health plans. The system must have the ability to integrate with the federal data hub and have account transfer functionality to accept application handoffs compatible with the Medicaid and MinnesotaCare eligibility and enrollment system maintained by the Department of Human Services.

(b) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance by February 15, 2020, the results of the request for information and an analysis of the option for a privatized marketplace, including estimated costs.

ARTICLE 11
HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2018, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $170;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) jurisprudence state examination, $75;

(11) Optometric Education Continuing Education data bank registration, $20; and

(12) data requests and labels, $50.

Sec. 2. Minnesota Statutes 2018, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts:

(1) for a licensed social worker, ~~$45~~ $54;

(2) for a licensed graduate social worker, ~~$45~~ $54;

(3) for a licensed independent social worker, ~~$45~~ $54;

(4) for a licensed independent clinical social worker, ~~$45~~ $54;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$85~~ $92.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $97;

(2) for a licensed graduate social worker, ~~$144~~ $172;

(3) for a licensed independent social worker, ~~$216~~ $258;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $284;

(5) for an emeritus inactive license, ~~$43.20~~ $51;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for ~~licensure are as follows~~ the two-year renewal term may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $97;

(2) for a licensed graduate social worker, ~~$144~~ $172;

(3) for a licensed independent social worker, ~~$216~~ $258; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $284.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, ~~$50~~ $60;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, ~~$100~~ $120;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, ~~$200~~ $240;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, ~~$400~~ $480; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, ~~$600~~ $720.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The fee for a license card as specified in section 148E.095 is $10.

(b) The fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 3. Minnesota Statutes 2018, section 150A.06, subdivision 3, is amended to read:

Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists, dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board, be waived for an applicant who presents a certificate of having passed all components of the National Board Dental Examinations or evidence of having maintained an adequate scholastic standing as determined by the board.

(b) The board shall waive the clinical examination required for licensure for any dentist applicant who is a graduate of a dental school accredited by the Commission on Dental Accreditation, who has passed all components of the National Board Dental Examinations, and who has satisfactorily completed a ~~Minnesota-based~~ postdoctoral general dentistry residency program (GPR) or an advanced education in general dentistry (AEGD) program after January 1, 2004. The postdoctoral program must be accredited by the Commission on Dental Accreditation, be of at least one year's duration, and include an outcome assessment evaluation assessing the resident's competence to practice dentistry. The board may require the applicant to submit any information deemed necessary by the board to determine whether the waiver is applicable.

Sec. 4. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 10. **Emeritus inactive license.** A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting pursuant to section 150A.05 or Minnesota Rules, part 3100.8500, who retires from active practice in the state may apply to the board for emeritus inactive licensure. An application for emeritus inactive licensure may be made on the biennial licensing form or by petitioning the board, and the applicant must pay a onetime application fee pursuant to section 150A.091, subdivision 19. In order to receive emeritus inactive licensure, the applicant must be in compliance with board requirements and cannot be the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the licensee to practice dentistry, dental therapy, dental hygiene, or dental assisting. An emeritus inactive license is not a license to practice, but is a formal recognition of completion of a person's dental career in good standing.

Sec. 5. Minnesota Statutes 2018, section 150A.06, is amended by adding a subdivision to read:

Subd. 11. **Emeritus active licensure.** (a) A person licensed to practice dentistry, dental therapy, dental hygiene, or dental assisting may apply for an emeritus active license if the person is retired from active practice, is in compliance with board requirements, and is not the subject of current disciplinary action resulting in suspension, revocation, disqualification, condition, or restriction of the license to practice dentistry, dental therapy, dental hygiene, or dental assisting.

(b) An emeritus active licensee may engage only in the following types of practice:

(1) pro bono or volunteer dental practice;

(2) paid practice not to exceed 500 hours per calendar year for the exclusive purpose of providing licensing supervision to meet the board's requirements; or

(3) paid consulting services not to exceed 500 hours per calendar year.

(c) An emeritus active licensee shall not hold out as a full licensee and may only hold out as authorized to practice as described in this subdivision. The board may take disciplinary or corrective action against an emeritus active licensee based on violations of applicable law or board requirements.

(d) A person may apply for an emeritus active license by completing an application form specified by the board and must pay the application fee pursuant to section 150A.091, subdivision 20.

(e) If an emeritus active license is not renewed every two years, the license expires. The renewal date is the same as the licensee's renewal date when the licensee was in active practice. In order to renew an emeritus active license, the licensee must:

(1) complete an application form as specified by the board;

(2) pay the required renewal fee pursuant to section 150A.091, subdivision 20; and

(3) report at least 25 continuing education hours completed since the last renewal, which must include:

(i) at least one hour in two different required CORE areas;

(ii) at least one hour of mandatory infection control;

(iii) for dentists and dental therapists, at least 15 hours of fundamental credits for dentists and dental therapists, and for dental hygienists and dental assistants, at least seven hours of fundamental credits; and

(iv) for dentists and dental therapists, no more than ten elective credits, and for dental hygienists and dental assistants, no more than six elective credits.

Sec. 6. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 19. **Emeritus inactive license.** An individual applying for emeritus inactive licensure under section 150A.06, subdivision 10, must pay a onetime fee of $50. There is no renewal fee for an emeritus inactive license.

Sec. 7. Minnesota Statutes 2018, section 150A.091, is amended by adding a subdivision to read:

Subd. 20. **Emeritus active license.** An individual applying for emeritus active licensure under section 150A.06, subdivision 11, must pay a fee upon application and upon renewal every two years. The fees for emeritus active license application and renewal are as follows: dentist, $212; dental therapist, $100; dental hygienist, $75; and dental assistant, $55.

Sec. 8. Minnesota Statutes 2018, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed advanced practice registered nurse. For purposes of sections 151.15, subdivision 4; 151.211,

subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.

Sec. 9. Minnesota Statutes 2018, section 151.06, is amended by adding a subdivision to read:

Subd. 6. **Information provision; sources of lower cost prescription drugs.** (a) The board shall publish a page on its website that provides regularly updated information concerning:

(1) patient assistance programs offered by drug manufacturers, including information on how to access the programs;

(2) the prescription drug assistance program established by the Minnesota Board of Aging under section 256.975, subdivision 9;

(3) the websites through which individuals can access information concerning eligibility for and enrollment in Medicare, medical assistance, MinnesotaCare, and other government-funded programs that help pay for the cost of health care;

(4) availability of providers that are authorized to participate under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b;

(5) having a discussion with the pharmacist or the consumer's health care provider about alternatives to a prescribed drug, including a lower cost or generic drug if the drug prescribed is too costly for the consumer; and

(6) any other resource that the board deems useful to individuals who are attempting to purchase prescription drugs at lower costs.

(b) The board must prepare educational materials, including brochures and posters, based on the information it provides on its website under paragraph (a). The materials must be in a form that can be downloaded from the board's website and used for patient education by pharmacists and by health care practitioners who are licensed to prescribe. The board is not required to provide printed copies of these materials.

(c) The board shall require pharmacists and pharmacies to make available to patients information on sources of lower cost prescription drugs, including information on the availability of the website established under paragraph (a).

Sec. 10. Minnesota Statutes 2018, section 151.211, subdivision 2, is amended to read:

Subd. 2. **Refill requirements.** Except as provided in subdivision 3, a prescription drug order may be refilled only with the written, electronic, or verbal consent of the prescriber and in accordance with the requirements of this chapter, the rules of the board, and where applicable, section 152.11. The date of such refill must be recorded and initialed upon the original prescription drug order, or within the electronically maintained record of the original prescription drug order, by the pharmacist, pharmacist intern, or practitioner who refills the prescription.

Sec. 11. Minnesota Statutes 2018, section 151.211, is amended by adding a subdivision to read:

Subd. 3. **Emergency prescription refills.** (a) A pharmacist may, using sound professional judgment and in accordance with accepted standards of practice, dispense a legend drug without a current prescription drug order from a licensed practitioner if all of the following conditions are met:

(1) the patient has been compliant with taking the medication and has consistently had the drug filled or refilled as demonstrated by records maintained by the pharmacy;

(2) the pharmacy from which the legend drug is dispensed has record of a prescription drug order for the drug in the name of the patient who is requesting it, but the prescription drug order does not provide for a refill, or the time during which the refills were valid has elapsed;

(3) the pharmacist has tried but is unable to contact the practitioner who issued the prescription drug order, or another practitioner responsible for the patient's care, to obtain authorization to refill the prescription;

(4) the drug is essential to sustain the life of the patient or to continue therapy for a chronic condition;

(5) failure to dispense the drug to the patient would result in harm to the health of the patient; and

(6) the drug is not a controlled substance listed in section 152.02, subdivisions 3 to 6, except for a controlled substance that has been specifically prescribed to treat a seizure disorder, in which case the pharmacist may dispense up to a 72-hour supply.

(b) If the conditions in paragraph (a) are met, the amount of the drug dispensed by the pharmacist to the patient must not exceed a 30-day supply, or the quantity originally prescribed, whichever is less, except as provided for controlled substances in paragraph (a), clause (6). If the standard unit of dispensing for the drug exceeds a 30-day supply, the amount of the drug dispensed or sold must not exceed the standard unit of dispensing.

(c) A pharmacist shall not dispense or sell the same drug to the same patient, as provided in this section, more than one time in any 12-month period.

(d) A pharmacist must notify the practitioner who issued the prescription drug order not later than 72 hours after the drug is sold or dispensed. The pharmacist must request and receive authorization before any additional refills may be dispensed. If the practitioner declines to provide authorization for additional refills, the pharmacist must inform the patient of that fact.

(e) The record of a drug sold or dispensed under this section shall be maintained in the same manner required for prescription drug orders under this section.

Sec. 12. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

(8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible

user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph ~~(c)~~ (d) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

(k) The board shall conduct random audits, on at least a quarterly basis, of electronic access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined in this section. A permissible user whose account has been selected for a random audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit is being conducted. Failure to respond may result in deactivation of access to the electronic system and referral to the appropriate health licensing board, or the commissioner of human services, for further action.

(l) A permissible user who has delegated the task of accessing the data in subdivision 4 to an agent or employee shall audit the use of the electronic system by delegated agents or employees on at least a quarterly basis to ensure compliance with permissible use as defined in this section. When a delegated agent or employee has been identified as inappropriately accessing data, the permissible user must immediately remove access for that individual and notify the board within seven days. The board shall notify all permissible users associated with the delegated agent or employee of the alleged violation.

Sec. 13. **[214.122] INFORMATION PROVISION; PHARMACEUTICAL ASSISTANCE PROGRAMS.**

(a) The Board of Medical Practice and the Board of Nursing shall at least annually inform licensees who are authorized to prescribe prescription drugs of the availability of the Board of Pharmacy's website that contains information on resources and programs to assist patients with the cost of prescription drugs. The boards shall provide licensees with the website address established by the Board of Pharmacy under section 151.06, subdivision 6, and the materials described under section 151.06, subdivision 6, paragraph (b).

(b) Licensees must make available to patients information on sources of lower cost prescription drugs, including information on the availability of the website established by the Board of Pharmacy under section 151.06, subdivision 6.

Sec. 14. **GUIDELINES AUTHORIZING PATIENT-ASSISTED MEDICATION ADMINISTRATION IN EMERGENCIES.**

(a) Within the limits of the board's available appropriation, the Emergency Medical Services Regulatory Board shall propose guidelines authorizing EMTs, AEMTs, and paramedics certified under Minnesota Statutes, section 144E.28, to assist a patient in emergency situations with administering prescription medications that are:

(1) carried by a patient;

(2) intended to treat adrenal insufficiency or other rare conditions that require emergency treatment with a previously prescribed medication;

(3) intended to treat a specific life-threatening condition; and

(4) administered via routes of delivery that are within the scope of training of the EMT, AEMT, or paramedic.

(b) The Emergency Medical Services Regulatory Board shall submit the proposed guidelines and draft legislation as necessary to the chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 1, 2020.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 12
MISCELLANEOUS

Section 1. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to read:

Subd. 20. **Dividends, distributions, or transfers.** (a) A for-profit health maintenance organization may pay dividends or make distributions or transfers, including to a legal entity that is an affiliate of the health maintenance organization or that is a subsidiary corporation of a local unit of government organized under chapter 383B, in accordance with section 60D.20, subdivision 2, except that the commissioner referenced in section 60D.20, subdivision 2, shall be the commissioner of health.

(b) If a nonprofit health maintenance organization plans on distributing or transferring an amount, including to a legal entity that is an affiliate of the health maintenance organization or that is a subsidiary corporation of a local unit of government organized under chapter 383B, that together with other distributions or transfers made within the preceding 12 months exceeds the greater of: (1) ten percent of the health maintenance organization's net worth on December 31 of the preceding year; or (2) the health maintenance organization's net income, not including realized capital gains, for the 12-month period ending on December 31 of the preceding year, but does not include pro rata distributions of any class of the health maintenance organization's own securities, the health maintenance organization must meet the requirements of paragraph (c).

(c) Prior to making a distribution or transfer identified in paragraph (b), a nonprofit health maintenance organization must notify the commissioner of the planned distribution

or transfer. Upon receipt of notification, the commissioner shall review the distribution or transfer to determine whether the distribution or transfer is reasonable in relation to the health maintenance organization's outstanding liabilities and the quality of the health maintenance organization's earnings and the extent to which the reported earnings include items such as surplus relief reinsurance transactions and reserve restrengthening, and in consideration of the factors described in section 60D.20, subdivision 4. No distribution or transfer shall be made by the health maintenance organization until: (1) 30 days after the commissioner has received notice and has not within this time period disapproved the distribution or transfer; or (2) the commissioner has approved the distribution or transfer within the 30-day period.

(d) For purposes of this subdivision, "affiliate" means an entity that controls, is controlled by, or is under common control with the health maintenance organization including a nonprofit hospital that is within the same integrated health care system as the health maintenance organization.

(e) The commissioner of health shall enforce this subdivision.

Sec. 3. Minnesota Statutes 2018, section 62K.07, is amended to read:

62K.07 INFORMATION DISCLOSURES.

Subdivision 1. **In general.** (a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

(c) Except for qualified health plans sold on MNsure, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by MNsure for qualified health plans sold through MNsure.

Subd. 2. **Prescription drug costs.** (a) Each health carrier that offers a prescription drug benefit in its individual health plans or small group health plans shall include in the applicable rate filing required under section 62A.02 the following information about covered prescription drugs:

(1) the 25 most frequently prescribed drugs in the previous plan year;

(2) the 25 most costly prescription drugs as a portion of the individual health plan's or small group health plan's total annual expenditures in the previous plan year;

(3) the 25 prescription drugs that have caused the greatest increase in total individual health plan or small group health plan spending in the previous plan year;

(4) the projected impact of the cost of prescription drugs on premium rates;

(5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing on any covered prescription drugs including deductibles, co-payments, or coinsurance in an amount that is greater than the amount the enrollee's health plan would pay for the drug absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

(6) if the health carrier prohibits third-party payments including manufacturer drug discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements including deductibles, co-payments, or coinsurance from applying toward the enrollee's cost-sharing obligations under the enrollee's health plan.

(b) The commissioner of commerce, in consultation with the commissioner of health, shall release a summary of the information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Subd. 3. **Enforcement.** ~~(d)~~ The commissioner of commerce shall enforce this section.

EFFECTIVE DATE. This section is effective for individual health plans and small group health plans offered, issued, sold, or renewed on or after January 1, 2021.

Sec. 4. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to read:

Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Sec. 5. Minnesota Statutes 2018, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section and section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Sec. 6. **[62Q.528] DRUG COVERAGE IN EMERGENCY SITUATIONS.**

A health plan that provides prescription drug coverage must provide coverage for a prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under

the terms of coverage that would apply had the prescription drug been dispensed according to a prescription.

Sec. 7. Minnesota Statutes 2018, section 525A.11, is amended to read:

525A.11 PERSONS THAT MAY RECEIVE ANATOMICAL GIFT; PURPOSE OF ANATOMICAL GIFT.

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) a hospital; accredited medical school, dental school, college, or university; organ procurement organization; or nonprofit organization in medical education or research, for research or education;

(2) subject to paragraph (b), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; and

(3) an eye bank or tissue bank.

(b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be transplanted into the individual, the part passes in accordance with paragraph (g) in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in paragraph (a) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of paragraph (c), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the

gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in paragraph (a) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

(1) if the part is an eye, the gift passes to the appropriate eye bank;

(2) if the part is tissue, the gift passes to the appropriate tissue bank; and

(3) if the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under paragraph (a), clause (2), passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section 525A.05 or 525A.10 or if the person knows that the decedent made a refusal under section 525A.07 that was not revoked. For purposes of this paragraph, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter affects the allocation of organs for transplantation or therapy.

(l) For purposes of paragraphs (c), clauses (1) and (4), and (g), no gift of an eye or a part of an eye shall be directly or indirectly processed by or distributed to a for profit entity, and no gift shall be sold or distributed for profit.

ARTICLE 13

FORECAST ADJUSTMENT

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2019" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2019.

	APPROPRIATIONS Available for the Year Ending June 30 2019
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (318,423,000)**
Appropriations by Fund	
2019	
General (317,538,000)	
Health Care Access 8,410,000	
Federal TANF (9,295,000)	
Subd. 2. **Forecasted Programs**	
(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**	
Appropriations by Fund	
General (19,361,000)	
Federal TANF (8,893,000)	
(b) **MFIP Child Care Assistance**	(16,789,000)
(c) **General Assistance**	(7,928,000)
(d) **Minnesota Supplemental Aid**	(549,000)
(e) **Housing Support**	(13,836,000)
(f) **Northstar Care for Children**	(19,027,000)

(g) **MinnesotaCare** 8,410,000

This appropriation is from the health care access fund.

(h) **Medical Assistance**

Appropriations by Fund	
General	(222,176,000)
Health Care Access	-0-

(i) **Alternative Care** -0-

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (17,872,000)

Subd. 3. **Technical Activities** (402,000)

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 14

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2020	**2021**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$ 8,059,011,000 $ 7,936,257,000**

Appropriations by Fund	2020	2021
General	7,269,109,000	7,141,320,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	513,185,000	515,750,000
Federal TANF	270,522,000	272,992,000
Lottery Prize	1,896,000	1,896,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **TANF Maintenance of Effort**

(a) **Nonfederal Expenditures.** The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet these basic TANF/MOE requirements, the commissioner may report as TANF/MOE expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) **Nonfederal Expenditures; Reporting.** For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) **Maintenance of Effort Expenditures Required.** The commissioner shall ensure that the MOE used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required

under Code of Federal Regulations, title 45, section 263.1.

(d) **Limitation; Exceptions.** The commissioner must not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43 (a)(2).

(e) **Supplemental Expenditures.** For the purposes of paragraph (d), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision.

(f) **Reduction of Appropriations; Exception.** The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or

aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, does not apply if the grants or aids are federal TANF funds.

(g) **IT Appropriations Generally.** This appropriation includes funds for information technology projects, services, and support. Notwithstanding Minnesota Statutes, section 16E.0466, funding for information technology project costs shall be incorporated into the service level agreement and paid to the Office of MN.IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(h) **Receipts for Systems Project.** Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Any unexpended balance in the appropriations for these projects does not cancel and is available for ongoing development and operations.

(i) **Federal SNAP Education and Training Grants.** Federal funds available during fiscal years 2020 and 2021 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This paragraph is effective the day following final enactment.

Subd. 3. **Working Family Credit as TANF/MOE.**

The commissioner may claim as TANF/MOE up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 4. **Central Office; Operations**

	Appropriations by Fund	
General	120,177,000	118,098,000
State Government Special Revenue	4,174,000	4,174,000
Health Care Access	20,709,000	20,709,000
Federal TANF	100,000	100,000

(a) **Administrative Recovery; Set-Aside.** The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) the statewide data management system authorized in Minnesota Statutes, section 125A.744, subdivision 3;

(2) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 245.495, paragraph (b);

(3) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) targeted case management under Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) residential services for children with severe emotional disturbance under Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) repayment of the special revenue maximization account as provided under Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

(b) **Transfer; Systems Account.** By June 30, 2021, the commissioner shall transfer $17,718,000 from the state systems account authorized in Minnesota Statutes, section 256.014, subdivision 2, to the general fund. This is a onetime transfer.

(c) **Transfer; Medical Assistance Holding Account.** By June 30, 2021, the commissioner shall transfer $2,600,000 from the medical assistance holding account under Minnesota Statutes, section 256.01, subdivision 2, to the general fund. This is a onetime transfer.

(d) **Transfer; SSI Interim Assistance Operations Account.** By June 30, 2021, the commissioner shall transfer $3,600,000 from the SSI interim assistance operations account under Minnesota Statutes, section 256D.06, subdivision 5, paragraph (e), to the general fund. This is a onetime transfer.

(e) **Transfer to Office of Legislative Auditor.** $300,000 in fiscal year 2020 and $300,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(f) **Transfer to Office of Legislative Auditor.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative

Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2a.

(g) **Fraud Prevention Investigations.** $425,000 in fiscal year 2020 and $425,000 in fiscal year 2021 are from the general fund for the fraud prevention investigation project under Minnesota Statutes, section 256.983.

(h) **Family Child Care Task Force.** $75,000 in fiscal year 2020 is from the general fund for the Family Child Care Task Force under article 2, section 45. This is a onetime appropriation.

(i) **Ombudsperson for Child Care Providers.** $114,000 in fiscal year 2020 and $120,000 in fiscal year 2021 are from the general fund for the ombudsperson for child care providers under Minnesota Statutes, section 245A.60.

(j) **Development of New Child Care Regulatory System.** $409,000 in fiscal year 2020 is from the general fund for development of a new child care regulatory system based on the risk-based violation levels under Minnesota Statutes, section 245A.055, subdivision 3, including use of an abbreviated inspection under Minnesota Statutes, section 245A.055, subdivision 2. Of this amount, $300,000 is for researching and developing the abbreviated inspection model based on key indicators, and $109,000 is to update the Electronic Licensing Inspection Checklist Information (ELICI) system. This is a onetime appropriation.

(k) **Reducing Appropriations for Unfilled Positions.** The general fund and nongeneral fund appropriations to the Department of Human Services for agency operations for the biennium ending June 30, 2021, are reduced for salary and benefit amounts attributable to any positions that are not filled within 180 days of the posting of the position. This paragraph applies only to positions that are posted in fiscal years 2019, 2020, and 2021. Reductions made under this section must be reflected as reductions in agency base budgets for fiscal years 2022 and 2023. The commissioner of management and budget must report to the chairs and ranking minority members of the senate and the house of representatives health and human services finance committees regarding the amount of reductions in appropriations under this section. This paragraph expires December 31, 2021.

(l) **Base Level Adjustment.** The general fund base is $120,223,000 in fiscal year 2022 and $122,712,000 in fiscal year 2023.

Subd. 5. **Central Office; Children and Families**

	Appropriations by Fund	
General	10,818,000	10,787,000
Federal TANF	2,582,000	2,582,000

(a) **Financial Institution Data Match and Payment of Fees.** The commissioner is authorized to allocate up to $310,000 each year in fiscal year 2020 and fiscal year 2021 from the state systems account authorized in Minnesota Statutes, section 256.014, subdivision 2, to make payments to financial institutions in exchange for performing data

matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

(b) **Base Level Adjustment.** The general fund base is $10,733,000 in fiscal year 2022 and $10,680,000 in fiscal year 2023.

Subd. 6. **Central Office; Health Care**

	Appropriations by Fund	
General	23,099,000	23,702,000
Health Care Access	24,313,000	24,313,000

Base Level Adjustment. The general fund base is $24,088,000 in fiscal year 2022 and $24,074,000 in fiscal year 2023.

Subd. 7. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	16,259,000	16,434,000
State Government Special Revenue	125,000	125,000

Office of Ombudsman for Long-Term Care. $1,312,000 in fiscal year 2020 and $1,501,000 in fiscal year 2021 are from the general fund for nine additional regional ombudsmen and one deputy director in the Office of Ombudsman for Long-Term Care, to perform the duties in Minnesota Statutes, section 256.9742.

Subd. 8. **Central Office; Community Supports**

	Appropriations by Fund	
General	34,558,000	34,168,000
Lottery Prize	163,000	163,000

(a) **Social Functioning Measurement Tool.** $100,000 in fiscal year 2020 is from the general fund for the commissioner to determine whether the Center for Victims of Torture's social functioning measurement tool can be adapted for other populations that receive targeted case management and other medical assistance services. This is a onetime appropriation and is available until June 30, 2023.

(b) **Person-Centered Telepresence Platform Expansion.** $100,000 in fiscal year 2020 is from the general fund for development of a proposal to expand and implement a statewide person-centered telepresence platform. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is $34,483,000 in fiscal year 2022 and $34,085,000 in fiscal year 2023.

Subd. 9. **Forecasted Programs; MFIP/DWP**

	Appropriations by Fund	
General	79,959,000	80,738,000
Federal TANF	75,607,000	76,851,000

Subd. 10. **Forecasted Programs; MFIP Child Care Assistance**	105,380,000	-0-
Subd. 11. **Forecasted Programs; General Assistance**	49,791,000	50,308,000

(a) **General Assistance Standard.** The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount

according to Laws 1997, chapter 85, article 3, section 54.

(b) **Emergency General Assistance Limit.** The amount appropriated for emergency general assistance is limited to no more than $6,729,812 in fiscal year 2020 and $6,729,812 in fiscal year 2021. Funds to counties shall be allocated by the commissioner using the allocation method under Minnesota Statutes, section 256D.06.

Subd. 12. **Forecasted Programs; Minnesota Supplemental Aid**	42,271,000	45,860,000
Subd. 13. **Forecasted Programs; Housing Support**	167,680,000	170,253,000
Subd. 14. **Forecasted Programs; Northstar Care for Children**	86,497,000	94,095,000
Subd. 15. **Forecasted Programs; MinnesotaCare**	25,100,000	27,665,000

This appropriation is from the health care access fund.

Subd. 16. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	5,610,367,000	5,616,974,000
Health Care Access	439,598,000	439,598,000

(a) **Behavioral Health Services.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for behavioral health services provided by hospitals identified under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (a), clause (4). The increase in payments shall be made by increasing the adjustment under Minnesota Statutes, section 256.969, subdivision 2b, paragraph (e), clause (2).

(b) **Base Level Adjustment.** The health care access fund base is $439,598,000 in fiscal year 2022 and $439,598,000 in fiscal year 2023.

Subd. 17. **Forecasted Programs; Alternative Care** 45,135,000 45,154,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 18. **Forecasted Programs; Chemical Dependency Treatment Fund** 127,503,000 131,750,000

Transfer; Consolidated Chemical Dependency Treatment Fund. Any balance remaining in the consolidated chemical dependency treatment fund at the end of fiscal year 2020, estimated to be $23,855,000, shall be transferred to the general fund.

Subd. 19. **Grant Programs; Support Services Grants**

Appropriations by Fund		
General	8,715,000	8,715,000
Federal TANF	96,312,000	96,311,000

Subd. 20. **Grant Programs; Basic Sliding Fee Child Care Assistance Grants** 44,655,000 -0-

Base Level Adjustment. The general fund base is $236,264,000 in fiscal year 2022 and zero in fiscal year 2023.

Subd. 21. **Grant Programs; Child Care Development Grants** 1,737,000 1,737,000

Subd. 22. **Grant Programs; Child Support Enforcement Grants** 50,000 50,000

Subd. 23. **Grant Programs; Children's Services Grants**

	Appropriations by Fund	
General	39,165,000	39,165,000
Federal TANF	140,000	140,000

Title IV-E Adoption Assistance. The commissioner shall allocate funds from the Title IV-E reimbursement to the state from the Fostering Connections to Success and Increasing Adoptions Act for adoptive, foster, and kinship families as required in Minnesota Statutes, section 256N.261.

Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network.

Subd. 24. **Grant Programs; Children and Community Service Grants** 58,201,000 58,201,000

Subd. 25. **Grant Programs; Children and Economic Support Grants**

	Appropriations by Fund	
General	22,665,000	22,065,000
Federal TANF	-0-	1,000,000

(a) **Minnesota Food Assistance Program.** Unexpended funds for the Minnesota food assistance program for fiscal year 2020 do not cancel but are available for this purpose in fiscal year 2021.

(b) **Pathways to Prosperity.** $1,000,000 in fiscal year 2021 is from the federal TANF fund for the unified benefit amount of the Minnesota Pathways to Prosperity and Well-Being pilot project. The commissioner shall award the grant only upon issuance of

formal approval of the pilot project plan as required under article 2, section 39, subdivision 1, paragraph (c), and after fulfillment of the condition in article 2, section 39, subdivision 1, paragraph (b), clause (3). No amount of the appropriation may be used for any other purpose of the pilot project. The base for this appropriation is $1,000,000 in fiscal year 2022 and $1,000,000 in fiscal year 2023. This is not an ongoing appropriation. The commissioner of management and budget shall not include a base amount for this appropriation in fiscal year 2024. This section expires June 30, 2023.

(c) **Homeless Youth Drop-In Program Grant.** Notwithstanding Minnesota Statutes, section 16B.97, $100,000 in fiscal year 2020 is from the general fund for a grant to an organization in Anoka County providing services and programming through a drop-in program to meet the basic needs, including mental health needs, of homeless youth in the north metropolitan suburbs, to develop a model of its homeless youth drop-in program that can be shared and replicated in other communities throughout Minnesota. This is a onetime appropriation.

(d) **Shelter-Linked Youth Mental Health Grants.** $500,000 in fiscal year 2020 is from the general fund for shelter-linked youth mental health grants under Minnesota Statutes, section 256K.46. This is a onetime appropriation and is available until June 30, 2023. This paragraph expires July 1, 2023.

Subd. 26. **Grant Programs; Health Care Grants**

	Appropriations by Fund		
General	3,711,000	3,711,000	
Health Care Access	3,465,000	3,465,000	

Subd. 27. **Grant Programs; Other Long-Term Care Grants** 1,925,000 1,925,000

Subd. 28. **Grant Programs; Aging and Adult Services Grants** 32,811,000 32,995,000

Subd. 29. **Grant Programs; Deaf and Hard-of-Hearing Grants** 2,675,000 2,675,000

Base Level Adjustment. The general fund base is $2,886,000 in fiscal year 2022 and $2,886,000 in fiscal year 2023.

Subd. 30. **Grant Programs; Disabilities Grants** 21,995,000 21,996,000

(a) **Semi-Independent Living Services Grants.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are from the general fund for reimbursement to lead agencies under Minnesota Statutes, section 252.275.

(b) **Parent-to-Parent Peer Support Grants.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for grants under Minnesota Statutes, section 256.4751.

(c) **Adaptive Fitness Access Grants.** $125,000 in fiscal year 2020 and $125,000 in fiscal year 2021 are from the general fund for the grant program under Minnesota Statutes, section 256.488.

(d) **Day Training and Habilitation Disability Waiver Rate System Transition Grants.** $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are from the general fund for day training and habilitation disability waiver

rate system transition grants under article 5, section 94.

(e) **Family Support Grants.** The general fund base for family support grants under Minnesota Statutes, section 252.32, is $10,278,000 in fiscal year 2022 and $8,278,000 in fiscal year 2023. The commissioner may use up to $2,000,000 of the 2022 fiscal year base funding to reimburse counties that issue family support grants in an amount that exceeds the county's allocation in fiscal year 2021.

(f) **Base Level Adjustment.** The general fund base is $27,996,000 in fiscal year 2022 and $25,996,000 in fiscal year 2023.

Subd. 31. **Grant Programs; Housing Support Grants** 9,339,000 10,389,000

(a) **Community-Based Housing and Behavioral Health Services for Opiate Addiction.** Notwithstanding Minnesota Statutes, section 16B.97, $25,000 in fiscal year 2020 and $25,000 in fiscal year 2021 are from the general fund for a grant to Oasis Central Minnesota, Inc., serving Morrison County to provide opioid programming, behavioral health services, and residential housing with employment services.

(b) **Transitional Housing Program.** Notwithstanding Minnesota Statutes, section 16B.97, $50,000 in fiscal year 2020 is from the general fund for a transitional housing and support program located in Rice County that serves women and children in crisis to enhance current services and supports and to determine if the program's model can be expanded

statewide. The commissioner of human services shall report by February 1, 2020, to the chairs and ranking minority members of the legislative committees with jurisdiction over transitional housing programs on the outcomes of the program and provide recommendations on expanding the program's model statewide. This is a onetime appropriation.

Subd. 32. **Grant Programs; Adult Mental Health Grants** 86,858,000 82,577,000

(a) **Taylor Hayden Violence Prevention Grants.** $100,000 in fiscal year 2020 is for violence prevention grants to nonprofit organizations with expertise in violence prevention to conduct violence prevention initiatives or public awareness and education campaigns on violence prevention. This is a onetime appropriation.

(b) **Project Legacy.** $250,000 in fiscal year 2020 is for a grant to Project Legacy to provide counseling and outreach to youth and young adults from families with a history of generational poverty. Money from this appropriation must be spent for mental health care, medical care, chemical dependency intervention, housing, and mentoring and counseling services for first generation college students. This is a onetime appropriation and is available until June 30, 2023. This paragraph expires July 1, 2023.

(c) **Housing Options for Persons with Serious Mental Illness.** $2,000,000 in fiscal year 2020 is for adult mental health grants under Minnesota Statutes, section 245.4661,

subdivision 9, paragraph (a), clause (2), to increase availability of housing options with supports for persons with serious mental illness. This is a onetime appropriation and is available until June 30, 2023. This paragraph expires July 1, 2023.

(d) **Officer-Involved Community-Based Care Coordination Grants.** $1,000,000 in fiscal year 2020 is for officer-involved community-based care coordination grants. Of this amount:

(1) $900,000 is for officer-involved community-based care coordination grants under Minnesota Statutes, section 245.4663. Of this amount, $500,000 shall be awarded to Blue Earth county. This is a onetime appropriation and is available until June 30, 2023; and

(2) $100,000 is for up to ten planning grants under article 3, section 38. In awarding these grants, the commissioner must place a priority on funding nonmetro programs. This is a onetime appropriation and is available until June 30, 2023.

This paragraph expires July 1, 2023.

(e) **Mobile Mental Health Crisis Response Team Funding.** $4,150,000 in fiscal year 2020 and $4,150,000 in fiscal year 2021 are for adult mental health grants under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (a), clause (1), to fund regional mobile mental health crisis response teams throughout the state. This is a onetime

appropriation and is available until June 30, 2023. This paragraph expires July 1, 2023.

(f) **Specialized Mental Health Community Supervision Pilot Project.** $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for a grant to Anoka County for establishment of a specialized mental health community supervision caseload pilot project. This is a onetime appropriation.

(g) **Base Level Adjustment.** The general fund base is $78,427,000 in fiscal year 2022 and $78,427,000 in fiscal year 2023.

Subd. 33. **Grant Programs; Child Mental Health Grants** 21,519,000 20,826,000

(a) **Community-Based Children's Mental Health Grant.** Notwithstanding Minnesota Statutes, section 16B.97, $193,000 in fiscal year 2020 is from the general fund for a grant to the Family Enhancement Center for staffing and administrative support to provide children access to expert mental health services regardless of a child's insurance status or income. This is a onetime appropriation and is available until June 30, 2021.

(b) **Telemedicine Equipment for School-Linked Mental Health Services.** $500,000 in fiscal year 2020 is for grants to purchase equipment to deliver school-linked mental health services by telemedicine. The grants may be awarded to new or existing providers statewide. The commissioner shall report to the legislative committees with jurisdiction over mental health on the effectiveness of the grants after funds appropriated under this section are expended.

This is a onetime appropriation and available until June 30, 2023. This paragraph expires July 1, 2023.

Subd. 34. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	2,386,000	2,386,000
Lottery Prize	1,733,000	1,733,000

(a) **Problem Gambling.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

(b) **Fetal Alcohol Spectrum Disorders Grants.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for a grant under Minnesota Statutes, section 254A.21, to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders.

Subd. 35. **Direct Care and Treatment - Generally**

Transfer; State-Operated Services Account. Any balance remaining in the state operated services account at the end of fiscal year 2019, estimated to be $13,000,000 shall be transferred to the general fund.

Subd. 36. **Direct Care and Treatment - Mental Health and Substance Abuse** 129,209,000 129,201,000

Base Level Adjustment. The general fund base is $129,197,000 in fiscal year 2022 and $129,197,000 in fiscal year 2023.

Subd. 37. **Direct Care and Treatment - Community-Based Services** 15,036,000 13,448,000

Base Level Adjustment. The general fund base is $13,447,000 in fiscal year 2022 and $13,447,000 in fiscal year 2023.

Subd. 38. **Direct Care and Treatment - Forensic Services** 112,126,000 115,342,000

Base Level Adjustment. The general fund base is $115,944,000 in fiscal year 2022 and $115,944,000 in fiscal year 2023.

Subd. 39. **Direct Care and Treatment - Sex Offender Program** 87,338,000 87,887,000

(a) **Transfer Authority.** Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

(b) **Base Level Adjustment.** The general fund base is $88,432,000 in fiscal year 2022 and $88,432,000 in fiscal year 2023.

Subd. 40. **Direct Care and Treatment - Operations** 47,499,000 47,708,000

(a) **Community Competency Restoration Task Force.** $200,000 in fiscal year 2020 is for the Community Competency Restoration Task Force under article 3, section 38. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $47,632,000 in fiscal year 2022 and $47,632,000 in fiscal year 2023.

Subd. 41. **Technical Activities** 95,781,000 96,008,000

(a) **Generally.** This appropriation is from the federal TANF fund.

(b) **Base Level Adjustment.** The TANF fund base is $96,360,000 in fiscal year 2022 and $96,620,000 in fiscal year 2023.

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 225,900,000 $ 227,953,000**

Appropriations by Fund

	2020	2021
General	157,897,000	157,988,000
State Government Special Revenue	56,290,000	58,252,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	129,824,000	129,096,000
State Government Special Revenue	7,150,000	6,969,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards

according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2020 and $1,156,000 in fiscal year 2021 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the amounts appropriated from the TANF fund each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first

year of the biennium does not cancel but is available for the second year.

(c) **Perinatal Hospice Grants.** $515,000 in fiscal year 2020 is from the general fund for perinatal hospice development, training, and awareness grants under article 9, section 54. Eligible entities may apply for multiple grants. The commissioner may use up to $15,000 for administration of these grants. This is a onetime appropriation and is available until June 30, 2023.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Safe Harbor for Sexually Exploited Youth.** $500,000 in fiscal year 2020 and $500,000 in fiscal year 2021 are from the general fund for the statewide program for safe harbor for sexually exploited youth. Of these amounts:

(1) $470,000 in fiscal year 2020 and $470,000 in fiscal year 2021 are for grants for comprehensive services, including trauma-informed, culturally specific services for sexually exploited youth under Minnesota Statutes, section 145.4716;

(2) $5,000 in fiscal year 2020 and $5,000 in fiscal year 2021 are for evaluation activities under Minnesota Statutes, section 145.4718. The base appropriation includes $45,000 in

fiscal year 2020 and $45,000 in fiscal year 2021 for evaluation activities under Minnesota Statutes, section 145.4718; and

(3) $25,000 in fiscal year 2020 and $25,000 in fiscal year 2021 are for training and protocol implementation.

(f) **Study on Breastfeeding Disparities.** $79,000 in fiscal year 2020 is from the general fund for a study on breastfeeding disparities.

(g) **Palliative Care Advisory Council.** $44,000 in fiscal year 2020 and $44,000 in fiscal year 2021 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059. This is a onetime appropriation.

(h) **Study on the Increase in Abortions after 20 Weeks.** $42,000 in fiscal year 2020 is from the general fund for an evaluation of the increase in abortions occurring after the gestational age of 20 weeks and the reasons for the increase. The commissioner shall report the findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by February 15, 2020. This is a onetime appropriation.

(i) **Positive Abortion Alternatives Grants.** $336,000 in fiscal year 2020 and $336,000 in fiscal year 2021 are from the general fund for the positive abortion alternatives grants under Minnesota Statutes, section 145.4235.

(j) **Mental Health Services for Pre- and Postpartum Women.** $100,000 in fiscal year 2020 is from the general fund for mental

health services to women suffering from pre- and postpartum mood and anxiety disorders under Minnesota Statutes, section 145.908. This is a onetime appropriation and is available until June 30, 2023.

(k) **Comprehensive Suicide Prevention.** $1,321,000 in fiscal year 2020 and $1,321,000 in fiscal year 2021 are from the general fund for a Minnesota-based suicide prevention lifeline as part of the suicide prevention plan described in Minnesota Statutes, section 145.56. This is a onetime appropriation and is available until June 30, 2023.

(l) **Health Professionals Loan Forgiveness.** $354,000 in fiscal year 2020 is from the general fund for transfer to the health professional education loan forgiveness program account for loan forgiveness for mental health professionals agreeing to practice in designated rural areas under Minnesota Statutes, section 144.1501, subdivision 2, paragraph (a), clause (1). This is a onetime appropriation and is available until June 30, 2023. If the commissioner does not receive enough qualified applicants to use the entire allocation of funds as required, the remaining funds may be used for loan forgiveness for mental health professionals agreeing to practice in underserved urban communities or may be allocated proportionally among other eligible professionals agreeing to practice in designated rural areas.

(m) **Cannabinoid Products Workgroup.** $10,000 in fiscal year 2020 is from the general

fund for the cannabinoid products workgroup under article 1, section 56. This is a onetime appropriation.

(n) **Base Level Adjustment.** The general fund base is $128,431,000 in fiscal year 2022 and $127,831,000 in fiscal year 2023.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	18,637,000	19,456,000
State Government Special Revenue	49,140,000	51,283,000

(a) **Public Health Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for equipment for the public health laboratory. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $18,801,000 in fiscal year 2022 and $18,801,000 in fiscal year 2023. The state government special revenue fund base is $51,283,000 in fiscal year 2022 and $51,290,000 in fiscal year 2023.

Subd. 4. **Health Operations** 9,436,000 9,436,000

Sec. 4. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 23,996,000 $ 24,016,000**

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners** 605,000 605,000

Subd. 3. **Board of Dentistry** 1,468,000 1,465,000

Emeritus Licensing Activities. $8,000 in fiscal year 2020 and $5,000 in fiscal year 2021 are for emeritus licensing activities under Minnesota Statutes, section 150A.06.

Subd. 4. **Board of Dietetics and Nutrition Practice**	145,000	145,000
Subd. 5. **Board of Marriage and Family Therapy**	376,000	377,000
Subd. 6. **Board of Medical Practice**	5,405,000	5,405,000

Health Professional Services Program. This appropriation includes $1,023,000 in fiscal year 2020 and $1,002,000 in fiscal year 2021 for the health professional services program.

Subd. 7. **Board of Nursing**	4,916,000	4,916,000
Subd. 8. **Board of Nursing Home Administrators**	2,898,000	2,898,000

(a) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2020 and $150,000 in fiscal year 2021 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(b) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $558,000 in fiscal year 2020 is for the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(c) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2020 and $200,000 in fiscal year 2021 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of appropriations currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 9. **Board of Optometry**	176,000	176,000
Subd. 10. **Board of Pharmacy**	3,326,000	3,338,000

$25,000 in fiscal year 2020 is for random audits under Minnesota Statutes, section 152.126, subdivision 6, paragraph (k), of permissible users of the prescription monitoring program. This is a onetime appropriation.

Subd. 11. **Board of Physical Therapy**	557,000	559,000
Subd. 12. **Board of Podiatric Medicine**	209,000	209,000

Subd. 13. **Board of Psychology**		1,285,000	1,285,000
Subd. 14. **Board of Social Work**		1,289,000	1,291,000
Subd. 15. **Board of Veterinary Medicine**		332,000	338,000
Subd. 16. **Board of Behavioral Health and Therapy**		669,000	669,000
Subd. 17. **Board of Occupational Therapy Practice**		340,000	340,000
Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD**	**$**	**3,747,000**	**$** **3,809,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2020 and $950,000 in fiscal year 2021 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2020 and $861,000 in fiscal year 2021 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2020 and $89,000 in fiscal year 2021 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,851,000 in fiscal year 2020 and $1,913,000 in fiscal year 2021 are for board operations. The base for this program is $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023.

(c) **Regional Grants.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for regional emergency medical services programs, to be distributed equally to the eight

emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $585,000 in fiscal year 2020 and $585,000 in fiscal year 2021 are for training grants under Minnesota Statutes, section 144E.35.

(e) **Base Level Adjustment.** The base is $3,776,000 in fiscal year 2022 and $3,776,000 in fiscal year 2023.

Sec. 6. **COUNCIL ON DISABILITY** **$ 1,014,000 $ 1,006,000**

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,688,000 $ 2,438,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 8. **OMBUDSPERSONS FOR FAMILIES** **$ 467,000 $ 467,000**

Sec. 9. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ 498,000 $ 498,000**

(a) **Transfer.** By June 30, 2019, the commissioner shall transfer $399,000,000 from the general fund to the health care access fund. This is a onetime transfer.

(b) **Transfer.** By June 30, 2020, the commissioner shall transfer $168,776,000 from the general fund to the health care access fund. This is a onetime transfer.

(c) **Transfer.** By June 30, 2022, the commissioner shall transfer $116,049,000 from the general fund to the health care access fund. This is a onetime transfer. This paragraph expires July 1, 2022.

(d) **Proven-Effective Practices Evaluation Activities.** $498,000 in fiscal year 2020 and $498,000 in fiscal year 2021 are from the general fund for evaluation activities under Minnesota Statutes, section 16A.055, subdivision 1a.

Sec. 10. **COMMISSIONER OF COMMERCE** **$ 39,000** **$ -0-**

Sec. 11. Laws 2017, First Special Session chapter 6, article 18, section 7, is amended to read:

Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,407,000** **$** ~~**2,427,000**~~ 2,177,000

Department of Psychiatry Monitoring. $100,000 in fiscal year 2018 and $100,000 in fiscal year 2019 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 12. **TRANSFERS.**

Subdivision 1. **Forecasted programs.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2021, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, housing support, the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services only to set up and manage operating budgets with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives

Health and Human Services Finance Committee quarterly about the transfers made under this subdivision.

Sec. 13. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2021, unless a different expiration date is explicit.

Sec. 15. **EFFECTIVE DATE.**

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.

Subd. 10. **Department.** "Department" means the Department of Human Services.

Subd. 10a. **Diversionary work program.** "Diversionary 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, diversionary work program, work benefit, Minnesota supplemental aid, general assistance, refugee cash assistance, at-home infant child care subsidy payments, and child support and maintenance distributed to the family under section 256.741, subdivision 2a. The following are deducted from income: funds used to pay for health insurance premiums for family members, and child or spousal support paid to or on behalf of a person or persons who live outside of the household. Income sources not included in this subdivision and section 256P.06, subdivision 3, are not counted.

Subd. 16. **Legal nonlicensed child care provider.** "Legal nonlicensed child care provider" means: (1) a child care provider who is excluded from licensing requirements under section 245A.03, subdivision 2; or (2) a child care provider authorized to provide care in a child's home under section 119B.09, subdivision 13, provided the provider only cares for related children, children from a single, unrelated family, or both related children and children from a single, unrelated family.

Subd. 17. **MFIP.** "MFIP" means the Minnesota family investment program, the state's TANF program under Public Law 104-193, Title I, and includes the MFIP program under chapter 256J and tribal contracts under section 119B.02, subdivision 2, or 256.01, subdivision 2.

Subd. 18. **Postsecondary educational systems.** "Postsecondary educational systems" means the University of Minnesota Board of Regents and the Board of Trustees of the Minnesota State Colleges and Universities.

Subd. 19. **Provider.** "Provider" means: (1) an individual or child care center or facility, either licensed or unlicensed, providing legal child care services as defined under section 245A.03; or (2) an individual or child care center or facility holding a valid child care license issued by another state or a tribe and providing child care services in the licensing state or in the area under the licensing tribe's jurisdiction. A legally unlicensed family child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

Subd. 19a. **Registration.** "Registration" means the process used by a county to determine whether the provider selected by a family applying for or receiving child care assistance to care for that family's children meets the requirements necessary for payment of child care assistance for care provided by that provider.

Subd. 19b. **Student parent.** "Student parent" means a person who is:

(1) under 21 years of age and has a child;

(2) pursuing a high school diploma or commissioner of education-selected high school equivalency certification;

(3) residing within a county that has a basic sliding fee waiting list under section 119B.03, subdivision 4; and

(4) not an MFIP participant.

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least three of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

Subd. 20a. **Transition year extension families.** "Transition year extension families" means families who have completed their transition year of child care assistance under this subdivision and who are eligible for, but on a waiting list for, services under section 119B.03. For purposes of sections 119B.03, subdivision 3, and 119B.05, subdivision 1, clause (2), families participating in extended transition year shall not be considered transition year families. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year extension child care may be used to support employment, approved education or training programs, or a job search that meets the requirements of section 119B.10 for the length of time necessary for families to be moved from the basic sliding fee waiting list into the basic sliding fee program.

Subd. 21. **Recoupment of overpayments.** "Recoupment of overpayments" means the reduction of child care assistance payments to an eligible family or a child care provider in order to correct an overpayment of child care assistance.

Subd. 22. **Service period.** "Service period" means the biweekly period used by the child care assistance program for billing and payment purposes.

119B.02 DUTIES OF COMMISSIONER.

Subdivision 1. **Child care services.** The commissioner shall develop standards for county and human services boards to provide child care services to enable eligible families to participate in employment, training, or education programs. Within the limits of available appropriations, the commissioner shall distribute money to counties to reduce the costs of child care for eligible families. The commissioner shall adopt rules to govern the program in accordance with this section. The rules must establish a sliding schedule of fees for parents receiving child care services. The rules shall provide that funds received as a lump-sum payment of child support arrearages shall not be counted as income to a family in the month received but shall be prorated over the 12 months following receipt and added to the family income during those months. The commissioner shall maximize the use of federal money under title I and title IV of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and other programs that provide

federal or state reimbursement for child care services for low-income families who are in education, training, job search, or other activities allowed under those programs. Money appropriated under this section must be coordinated with the programs that provide federal reimbursement for child care services to accomplish this purpose. Federal reimbursement obtained must be allocated to the county that spent money for child care that is federally reimbursable under programs that provide federal reimbursement for child care services. The counties shall use the federal money to expand child care services. The commissioner may adopt rules under chapter 14 to implement and coordinate federal program requirements.

Subd. 2. **Contractual agreements with tribes.** The commissioner may enter into contractual agreements with a federally recognized Indian tribe with a reservation in Minnesota to carry out the responsibilities of county human service agencies to the extent necessary for the tribe to operate child care assistance programs under sections 119B.03 and 119B.05. An agreement may allow the state to make payments for child care assistance services provided under section 119B.05. The commissioner shall consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and tribal child care services. Funding to support services under section 119B.03 may be transferred to the federally recognized Indian tribe with a reservation in Minnesota from allocations available to counties in which reservation boundaries lie. When funding is transferred under section 119B.03, the amount shall be commensurate to estimates of the proportion of reservation residents with characteristics identified in section 119B.03, subdivision 6, to the total population of county residents with those same characteristics.

Subd. 3. **Supervision of counties.** The commissioner shall supervise child care programs administered by the counties through standard-setting, technical assistance to the counties, approval of county child care fund plans, and distribution of public money for services. The commissioner shall provide training and other support services to assist counties in planning for and implementing child care assistance programs. The commissioner shall adopt rules under chapter 14 that establish minimum administrative standards for the provision of child care services by county boards of commissioners.

Subd. 4. **Universal application form.** The commissioner must develop and make available to all counties a universal application form for child care assistance under this chapter. The commissioner may develop and make available to all counties a child care addendum form to be used to supplement the combined application form for MFIP, DWP, or Food Support or to supplement other statewide application forms for public assistance programs for families applying for one of these programs in addition to child care assistance. The application must provide notice of eligibility requirements for assistance and penalties for wrongfully obtaining assistance.

Subd. 5. **Program integrity.** For child care assistance programs under this chapter, the commissioner shall enforce the requirements for program integrity and fraud prevention investigations under sections 256.046, 256.98, and 256.983.

Subd. 6. **Data.** Data collected, maintained, used, or disseminated by the welfare system pertaining to persons selected as legal nonlicensed child care providers by families receiving child care assistance shall be treated as licensing data as provided in section 13.46, subdivision 4.

Subd. 7. **Child care market rate survey.** Biennially, the commissioner shall survey prices charged by child care providers in Minnesota to determine the 75th percentile for like-care arrangements in county price clusters.

119B.025 DUTIES OF COUNTIES.

Subdivision 1. **Applications.** (a) The county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

(8) spousal support and child support payments made to persons outside the household;

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

Subd. 2. **Social Security numbers.** The county must request Social Security numbers from all applicants for child care assistance under this chapter. A county may not deny child care assistance solely on the basis of failure of an applicant to report a Social Security number.

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

(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

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.

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

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.

(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

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:

(1) a participant's employment or education program ends permanently;

(2) the other parent moves in and does not participate in an authorized activity;

(3) a participant's MFIP assistance ends and the participant is not participating in an authorized activity or the participant's participation in an authorized activity is unknown;

(4) a student parent under section 119B.011, subdivision 19b, stops attending school; or

(5) a participant receiving basic sliding fee child care assistance or transition year child care assistance applied for MFIP assistance and is not participating in an authorized activity or the participant's participation in an authorized activity is unknown.

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan that meets the requirements of section 119B.10, subdivision 3, or have an MFIP or DWP employment plan. If child care assistance continues, the amount of child care authorized shall continue at the same number or more hours until redetermination, unless a condition in section 119B.095, subdivision 2, paragraph (c), applies. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. If child care assistance continues, the amount of child care authorized is based on section 119B.10. A family subject to section 119B.095, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.

119B.11 COUNTY CONTRIBUTION.

Subdivision 1. **County contributions required.** (a) In addition to payments from basic sliding fee child care program participants, each county shall contribute from county tax or other sources a fixed local match equal to its calendar year 1996 required county contribution reduced by the administrative funding loss that would have occurred in state fiscal year 1996 under section 119B.15. The commissioner shall recover funds from the county as necessary to bring county expenditures into compliance with this subdivision. The commissioner may accept county contributions, including contributions above the fixed local match, in order to make state payments.

(b) The commissioner may accept payments from counties to:

(1) fulfill the county contribution as required under subdivision 1;

(2) pay for services authorized under this chapter beyond those paid for with federal or state funds or with the required county contributions; or

(3) pay for child care services in addition to those authorized under this chapter, as authorized under other federal, state, or local statutes or regulations.

(c) The county payments must be deposited in an account in the special revenue fund. Money in this account is appropriated to the commissioner for child care assistance under this chapter and other applicable statutes and regulations and is in addition to other state and federal appropriations.

Subd. 2a. **Recovery of overpayments.** (a) An amount of child care assistance paid to a recipient in excess of the payment due is recoverable by the county agency under paragraphs (b) and (c), even when the overpayment was caused by agency error or circumstances outside the responsibility and control of the family or provider.

(b) An overpayment must be recouped or recovered from the family if the overpayment benefited the family by causing the family to pay less for child care expenses than the family otherwise would have been required to pay under child care assistance program requirements. If the family remains eligible for child care assistance, the overpayment must be recovered through recoupment as identified in Minnesota Rules, part 3400.0187, except that the overpayments must be calculated and collected on a service period basis. If the family no longer remains eligible for child care assistance, the county may choose to initiate efforts to recover overpayments from the family for overpayment less than $50. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the family. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the

amount of the overpayment. A family with an outstanding debt under this subdivision is not eligible for child care assistance until: (1) the debt is paid in full; or (2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the family is in compliance with the arrangements.

(c) The county must recover an overpayment from a provider if the overpayment did not benefit the family by causing it to receive more child care assistance or to pay less for child care expenses than the family otherwise would have been eligible to receive or required to pay under child care assistance program requirements, and benefited the provider by causing the provider to receive more child care assistance than otherwise would have been paid on the family's behalf under child care assistance program requirements. If the provider continues to care for children receiving child care assistance, the overpayment must be recovered through reductions in child care assistance payments for services as described in an agreement with the county. The provider may not charge families using that provider more to cover the cost of recouping the overpayment. If the provider no longer cares for children receiving child care assistance, the county may choose to initiate efforts to recover overpayments of less than $50 from the provider. If the overpayment is greater than or equal to $50, the county shall seek voluntary repayment of the overpayment from the provider. If the county is unable to recoup the overpayment through voluntary repayment, the county shall initiate civil court proceedings to recover the overpayment unless the county's costs to recover the overpayment will exceed the amount of the overpayment. A provider with an outstanding debt under this subdivision is not eligible to care for children receiving child care assistance until:

(1) the debt is paid in full; or

(2) satisfactory arrangements are made with the county to retire the debt consistent with the requirements of this chapter and Minnesota Rules, chapter 3400, and the provider is in compliance with the arrangements.

(d) When both the family and the provider acted together to intentionally cause the overpayment, both the family and the provider are jointly liable for the overpayment regardless of who benefited from the overpayment. The county must recover the overpayment as provided in paragraphs (b) and (c). When the family or the provider is in compliance with a repayment agreement, the party in compliance is eligible to receive child care assistance or to care for children receiving child care assistance despite the other party's noncompliance with repayment arrangements.

Subd. 3. **Federal money; state recovery.** The commissioner shall recover from counties any state or federal money that was spent for persons found to be ineligible, except if the recovery is made by a county agency using any method other than recoupment, the county may keep 25 percent of the recovery. If a federal audit exception is taken based on a percentage of federal earnings, all counties shall pay a share proportional to their respective federal earnings during the period in question.

Subd. 4. **Maintenance of funding effort.** To receive money through this program, each county shall certify, in its annual plan to the commissioner, that the county has not reduced allocations from other federal and state sources, which, in the absence of the child care fund, would have been available for child care assistance. However, the county must continue contributions, as necessary, to maintain on the basic sliding fee program, families who are receiving assistance on July 1, 1995, until the family loses eligibility for the program or until a family voluntarily withdraws from the program. This subdivision does not affect the local match required for this program under other sections of the law.

119B.12 SLIDING FEE SCALE.

Subdivision 1. **Fee schedule.** All changes to parent fees must be implemented on the first Monday of the service period following the effective date of the change.

PARENT FEE SCHEDULE. The parent fee schedule is as follows, except as noted in subdivision 2:

Income Range (as a percent of the state median income, except at the start of the first tier)	Co-payment (as a percentage of adjusted gross income)
0-74.99% of federal poverty guidelines	$0/biweekly
75.00-99.99% of federal poverty guidelines	$2/biweekly
100.00% of federal poverty guidelines-27.72%	2.61%

27.73-29.04%	2.61%
29.05-30.36%	2.61%
30.37-31.68%	2.61%
31.69-33.00%	2.91%
33.01-34.32%	2.91%
34.33-35.65%	2.91%
35.66-36.96%	2.91%
36.97-38.29%	3.21%
38.30-39.61%	3.21%
39.62-40.93%	3.21%
40.94-42.25%	3.84%
42.26-43.57%	3.84%
43.58-44.89%	4.46%
44.90-46.21%	4.76%
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.

(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.

(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

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

(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,

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

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.

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;

(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.

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;

(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

to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.

256I.05 MONTHLY RATES.

Subd. 3. **Limits on rates.** When a room and board rate is used to pay for an individual's room and board, the rate payable to the residence must not exceed the rate paid by an individual not receiving a room and board rate under this chapter.

256R.53 FACILITY SPECIFIC EXEMPTIONS.

Subd. 2. **Nursing facility in Breckenridge.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the city of Breckenridge, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by 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.

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.

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;

(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

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.

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;

(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.