# SENATE
## STATE OF MINNESOTA
## NINETY-FIRST SESSION

# S.F. No. 4

**(SENATE AUTHORS: ABELER)**

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 01/10/2019 | | Introduction and first reading |
| | | Referred to Family Care and Aging |

A bill for an act

relating to human services; clarifying counted income for eligibility determinations for public assistance and child care programs; creating surety bond requirements for child care program providers; modifying surety bond requirements for personal care assistance service providers and durable medical supply providers; modifying documentation requirements for child care program providers, personal care assistance providers, mental health providers, and home and community-based services providers; modifying commissioner of human services' authority to exclude providers from programs administered by the commissioner; modifying provider enrollment requirements for medical assistance; establishing a visit verification system for home and community-based services; requiring a report; appropriating money; amending Minnesota Statutes 2018, sections 119B.09, subdivision 4; 119B.125, subdivision 6, by adding a subdivision; 144A.479, by adding a subdivision; 245.095; 256.476, subdivision 10; 256.98, subdivisions 1, 8; 256B.02, subdivision 7, by adding a subdivision; 256B.04, subdivision 21; 256B.056, subdivisions 3, 4; 256B.0623, subdivision 5; 256B.0625, subdivisions 17, 43, by adding subdivisions; 256B.064, subdivision 1b; 256B.0651, subdivision 17; 256B.0659, subdivisions 3, 12, 13, 14, 19, 21, 24; 256B.0949, subdivision 15; 256B.4912, by adding subdivisions; 256B.5014; 256B.85, subdivision 10; 256J.08, subdivision 47; 256J.21, subdivision 2; 256L.01, subdivision 5; 256P.04, subdivision 4; 256P.06, subdivision 3; Laws 2017, First Special Session chapter 6, article 3, section 49; repealing Minnesota Statutes 2018, section 256B.0705.

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

Section 1. 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 must be verified with documentary evidence. 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. If the applicant does not have sufficient evidence of income, verification must be obtained from the source of the income.

Sec. 2. Minnesota Statutes 2018, section 119B.125, is amended by adding a subdivision to read:

Subd. 1c. **Surety bond coverage required.** The provider is required to provide proof of surety bond coverage of $..... at authorization and reauthorization if the provider's child care assistance program payments in the previous calendar year total $100,000 or more. 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.

Sec. 3. 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. 4. 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. 5. 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. 6. Minnesota Statutes 2018, section 256.476, subdivision 10, is amended to read:

Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, a person's legal representative, or other authorized representative that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; ~~and~~

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports~~.~~; and

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

Sec. 7. 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. 8. 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. 9. 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. 10. 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. 11. 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 locations must enroll each 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) adult rehabilitative mental health services according to section 256B.0623;

(2) autism early intensive behavioral intervention benefits according to section 256B.0949;

(3) home and community-based waiver services, consumer directed community supports; and

(4) 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 ~~allow for recovery of costs and fees in pursuing a claim on the bond~~ be in a form approved by the commissioner, renewed annually, and allow for recovery of the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss.

(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.

Sec. 12. 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. 13. 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. 14. Minnesota Statutes 2018, section 256B.0623, subdivision 5, is amended to read:

Subd. 5. **Qualifications of provider staff.** (a) Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified under one of the following criteria:

(1) a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6). If the recipient has a current diagnostic assessment by a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), recommending receipt of adult mental health rehabilitative services, the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;

(2) a mental health practitioner as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional;

(3) a certified peer specialist under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional; or

(4) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who:

(i) is at least 21 years of age;

(ii) has a high school diploma or equivalent;

(iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery from mental illness, mental health de-escalation techniques, recipient rights,

recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and

(iv) meets the qualifications in paragraph (b).

(b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3):

(1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has:

(i) three years of personal life experience with serious mental illness;

(ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability;

(2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;

(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year;

(iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and

(v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or

(3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services:

(i) satisfies clause (2), items (ii) to (iv); and

(ii) has 40 hours of additional continuing education on mental health topics during the first year of employment.

(c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).

(d) For purposes of this subdivision, "behavioral sciences or related fields" means an education from an accredited college or university and includes but is not limited to social work, psychology, sociology, community counseling, family social science, child development, child psychology, community mental health, addiction counseling, counseling and guidance, special education, and other fields as approved by the commissioner.

(e) Individual provider staff must enroll with the department as a mental health professional, a mental health practitioner, a certified peer specialist, or a mental health rehabilitation worker, after clearing a background check. Before an individual provider staff provides services, the provider entity must initiate a background study on the individual provider staff under chapter 245C. The provider entity must have received a notice from the commissioner that the individual provider staff is:

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

(2) is disqualified, but the individual provider staff has received a set-aside of the disqualification under section 245C.22.

Sec. 15. 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.** The amendments to paragraph (c) are effective January 1, 2020.

Sec. 16. 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 July 1, 2019.

Sec. 17. 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. 18. 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. 19. 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) Mental health provider travel time under this subdivision covers the time the provider is in transit to deliver a mental health service to a recipient at a location that is not the provider's usual place of business or to the next location for delivery of a covered mental health service, and the time a provider is in transit returning from the location of the last recipient who received services on that day to 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 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) If the first occurrence of mental health provider travel time in a day begins at a location other than the provider's usual place of business, the provider shall bill for the lesser of the travel time between the location and the recipient and the travel time between the provider's usual place of business and the recipient. This provision does not apply to mental health crisis services provided under section 256B.0624 outside of normal business hours if on-call staff are dispatched directly from a location other than the provider's usual place of business.

(e) Mental health provider travel time may be billed for not more than one round trip per recipient per day.

(f) As a condition of payment, a provider must document each occurrence of mental health provider travel time according to this subdivision. Program funds paid for mental

health provider travel time that is not documented according to this subdivision shall be recovered by the department. The documentation may be collected and maintained electronically or in paper form but must be made available and produced upon request. A provider must compile records that meet the following requirements for each occurrence:

(1) the record must be written in English and must be legible according to the standard of a reasonable person;

(2) the recipient's name and date of birth or individual identification number must be on each page of the record;

(3) the reason the provider must travel to provide services, if not otherwise documented in the recipient's individual treatment plan; and

(4) each entry in the record must document:

(i) the date on which the entry is made;

(ii) the date the travel occurred;

(iii) the printed last name, first name, and middle initial of the provider and the provider's identification number, if the provider has one;

(iv) the signature of the traveling provider stating that the provider understands that it is a federal crime to provide false information on service billings for medical assistance payments;

(v) the location of the provider's usual place of business;

(vi) the address, or the description if the address is not available, of both the origination site and destination site and the travel time for the most direct route from the origination site to the destination site;

(vii) any unusual travel conditions that may cause a need to bill for additional time over and above what an electronic source document shows the mileage and time necessary to travel from the origination site to destination site;

(viii) the time the provider left the origination site and the time the provider arrived at the destination site, with a.m. and p.m. designations; and

(ix) the electronic source documentation used to calculate the most direct route detailing driving directions, mileage, and time.

Sec. 20. 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. 21. 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 may be withheld or that the provider's participation in medical assistance has been or may 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. 22. 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. 23. 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. 24. 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. 25. Minnesota Statutes 2018, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(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~~.~~;

(7) the month, day, and year, and arrival and departure times with a.m. or p.m. designations of each visit or call to the recipient when services are provided; and

(8) the total amount of time of each service visit with 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) the time spent documenting services;

~~(2)~~ (3) agency administrative activities;

~~(3)~~ (4) training other than the individualized training required to provide care for a recipient; and

~~(4)~~ (5) any other activity that is not described in this section.

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

Sec. 26. 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. 27. 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~~ the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss;

(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;

(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.

Sec. 28. 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. 29. Minnesota Statutes 2018, section 256B.0949, subdivision 15, is amended to read:

Subd. 15. **EIDBI provider qualifications.** (a) A QSP must be employed by an agency and be:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development; or

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition

or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(b) A level I treatment provider must be employed by an agency and:

(1) have at least 2,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented coursework or hours of experience; and

(2) have or be at least one of the following:

(i) a master's degree in behavioral health or child development or related fields including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) a board-certified behavior analyst; or

(iv) a board-certified assistant behavior analyst with 4,000 hours of supervised clinical experience that meets all registration, supervision, and continuing education requirements of the certification.

(c) A level II treatment provider must be employed by an agency and must be:

(1) a person who has a bachelor's degree from an accredited college or university in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy; and meet at least one of the following:

(i) has at least 1,000 hours of supervised clinical experience or training in examining or treating people with ASD or a related condition or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience;

(ii) has certification as a board-certified assistant behavior analyst from the Behavior Analyst Certification Board;

(iii) is a registered behavior technician as defined by the Behavior Analyst Certification Board; or

(iv) is certified in one of the other treatment modalities recognized by the department; or

(2) a person who has:

(i) an associate's degree in a behavioral or child development science or related field including, but not limited to, mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) at least 2,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health behavioral aide or level III treatment provider may be included in the required hours of experience; or

(4) a person who is a graduate student in a behavioral science, child development science, or related field and is receiving clinical supervision by a QSP affiliated with an agency to meet the clinical training requirements for experience and training with people with ASD or a related condition; or

(5) a person who is at least 18 years of age and who:

(i) is fluent in a non-English language;

(ii) completed the level III EIDBI training requirements; and

(iii) receives observation and direction from a QSP or level I treatment provider at least once a week until the person meets 1,000 hours of supervised clinical experience.

(d) A level III treatment provider must be employed by an agency, have completed the level III training requirement, be at least 18 years of age, and have at least one of the following:

(1) a high school diploma or commissioner of education-selected high school equivalency certification;

(2) fluency in a non-English language; or

(3) one year of experience as a primary personal care assistant, community health worker, waiver service provider, or special education assistant to a person with ASD or a related condition within the previous five years.

(e) All qualified EIDBI providers must enroll with the department as an applicable EIDBI provider type. Before a qualified EIDBI provider provides services, the agency must initiate a background study on the qualified EIDBI provider under chapter 245C, and the agency must have received a notice from the commissioner that the qualified EIDBI provider is:

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

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

Sec. 30. 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; consumer support grants under section 256.476; 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) 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.

(f) 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.

(g) 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.

(h) 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. 31. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision to read:

Subd. 11. **Service documentation and billing requirements.** (a) Only a service provided as specified in a federally approved waiver plan, as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, is eligible for payment. As a condition of payment, a home and community-based waiver provider must document each time a service was provided to a recipient. Payment for a service not documented according to this subdivision

or not specified in a federally approved waiver plan shall be recovered by the department under section 256B.064. For payment of a service, documentation must meet the standards in paragraphs (b) to (j).

(b) The service delivered to a recipient must be documented in the provider's record of service delivery.

(c) The recipient's name and recipient identification number must be entered on each document.

(d) The provider's record of service delivery must be in English and must be legible according to the standard of a reasonable person.

(e) The provider's record of service delivery must contain a statement that it is a federal crime to provide false information on service billings for medical assistance or services under a federally approved waiver plan, as authorized under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

(f) If an entry is for a time-based service, each entry in the provider's record of service delivery must contain:

(1) the date the entry was made;

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

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

(4) 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; 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.

(g) If an entry is for a service that is not a time-based service, other than equipment or supplies, each entry in the provider's record of service delivery must contain:

(1) the date the entry of service delivery was made;

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

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

(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; and

(5) for services under section 245D.03, subdivision 1, paragraph (c), clause (3), entries into the record under this subdivision shall occur at least monthly.

(h) If the service billed is transportation, each entry must contain the information from paragraphs (b) to (e) and (g). A provider must:

(1) maintain odometer and other records pursuant to section 256B.0625, subdivision 17b, paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle and driver for a transportation service that is billed by mileage, except if the provider is a common carrier as defined by Minnesota Rules, part 9505.0315, subpart 1, item B, or publicly operated transit systems. This documentation may be collected and maintained electronically or in paper form, but must be made available and produced upon request;

(2) maintain documentation demonstrating that the vehicle and the driver meet the standards determined by the Department of Human Services on vehicle and driver qualifications;

(3) only bill a waivered transportation service if the transportation is not to or from a health care service available through the Medicaid state plan; and

(4) only bill a waivered transportation service when the rate for waiver service does not include transportation.

(i) If the service provided is equipment or supplies, the documentation must contain the information from paragraphs (b) to (e) and:

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

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

(3) the quantity of supplies delivered or purchased;

(4) the shipping invoice or a delivery service tracking log or other documentation showing the date of delivery that proves the equipment or supplies were delivered to the recipient or a receipt if the equipment or supplies were purchased by the recipient; and

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

(j) A service defined as "adult day care" under section 245A.02, subdivision 2a, must meet the documentation standards specified in paragraphs (b) to (f) and must comply with the following:

(1) individual recipient's service records must contain the following:

(i) the recipient's needs assessment and current plan of care according to section 245A.143, subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, if applicable; and

(ii) the day, month, and year the service was provided, including arrival and departure times with a.m. and p.m. designations and the first and last name of the individual making the entry;

(2) entity records must contain the following:

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

(ii) 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;

(iii) the location where the service was provided and, if the location is an alternate location than the primary place of service, the record must contain the address, or the description if the address is not available, 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; and

(iv) documentation that the program is maintaining the appropriate staffing levels according to licensing standards and the federally approved waiver plan.

Sec. 32. 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. 33. 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. 34. 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. 35. 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. 36. 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. 37. 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. 38. 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. 39. 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).

~~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. 40. **DIRECTIONS TO THE COMMISSIONER.**

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. 41. **UNIVERSAL IDENTIFICATION NUMBER FOR CHILDREN IN EARLY CHILDHOOD PROGRAMS.**

The commissioners of the Departments of Education, Health, and Human Services shall establish and implement a universal identification number for children participating in early childhood programs to eliminate potential duplication in programs. The commissioners shall identify the necessary process of establishing the universal identification number and implement a statewide universal identification number for children by July 1, 2020.

Sec. 42. **APPROPRIATION; FRAUD PREVENTION INVESTIGATIONS.**

$..... is appropriated in fiscal year 2020 and $..... is appropriated in fiscal year 2021 from the general fund to the commissioner of human services for the fraud prevention investigation project described in Minnesota Statutes, section 256.983.

Sec. 43. **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. 44. **REPEALER.**

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

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

**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.