SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 3937

(SENATE AUTHORS: ABELER and Hoffman)

DATE	D-PG	OFFICIAL STATUS
04/12/2018	7290	Introduction and first reading Referred to Human Services Reform Finance and Policy
04/19/2018	7618a	Comm report: To pass as amended and re-refer to Finance See SF3656, Art. 40, Sec. 2-7, 9-10, 12-14, , 16, 18, 21, 24; Art. 41, Sec. 7-9; Art. 42

A bill for an act

relating to human services; modifying provisions governing children and families, licensing, state-operated services, chemical and mental health, community supports and continuing care, and health care; requiring reports; appropriating money; amending Minnesota Statutes 2016, sections 119B.011, subdivision 19, by adding a subdivision; 119B.02, subdivision 7; 119B.03, subdivision 9; 245.4889, by adding a subdivision; 245A.175; 245D.071, subdivision 5; 245D.091, subdivisions 2, 3, 4; 254A.035, subdivision 2; 254B.02, subdivision 1; 254B.06, subdivision 1; 256B.0625, by adding subdivisions; 256B.0659, subdivisions 3a, 11, 21, 24, 28, by adding a subdivision; 256B.0915, subdivision 6; 256B.092, subdivisions 1b, 1g; 256B.4914, subdivision 4; 256I.04, by adding subdivisions; 256K.45, subdivision 2; 256M.41, subdivision 3, by adding a subdivision; 256N.24, by adding a subdivision; 260.835, subdivision 2; 626.556, by adding a subdivision; Minnesota Statutes 2017 Supplement, sections 119B.011, subdivision 20; 119B.025, subdivision 1; 119B.06, subdivision 1; 119B.09, subdivision 1; 119B.095, subdivision 2; 119B.13, subdivision 1; 245.4889, subdivision 1; 245A.03, subdivision 7; 245A.06, subdivision 8; 245A.11, subdivision 2a; 245D.03, subdivision 1; 256B.0625, subdivision 17; 256B.0911, subdivisions 1a, 3a, 3f, 5; 256B.49, subdivision 13; 256B.4914, subdivisions 2, 3, 5, 10, 10a; 256I.03, subdivision 8; 256I.04, subdivision 2b; 256I.05, subdivision 3; Laws 2014, chapter 312, article 27, section 76; Laws 2017, First Special Session chapter 6, article 1, section 52; article 3, section 49; proposing coding for new law in Minnesota Statutes, chapters 246; 260C; repealing Minnesota Statutes 2016, sections 256B.0625, subdivision 18b; 256B.0705.

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

ARTICLE 1

CHILDREN AND FAMILIES; LICENSING

Section 1. Minnesota Statutes 2016, section 119B.011, is amended by adding a subdivision to read:

Subd. 13b. **Homeless.** "Homeless" means a self-declared housing status as defined in the McKinney-Vento Homeless Assistance Act and United States Code, title 42, section 11302, paragraph (a).

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 2. Minnesota Statutes 2016, section 119B.011, subdivision 19, is amended to read:

Subd. 19. **Provider.** "Provider" means: (1) an individual or child care center or facility~~, either licensed or unlicensed,~~ providing licensed legal child care services as defined under section 245A.03; ~~or~~ (2) a license exempt center required to be certified under chapter 245G;

(3) an individual or child care center or facility ~~holding~~ that:

(i) holds a valid child care license issued by another state or a tribe ~~and providing~~;

(ii) provides child care services in the licensing state or in the area under the licensing tribe's jurisdiction; and

(iii) is in compliance with federal health and safety requirements as certified by the licensing state or tribe, or as determined by receipt of child care development block grant funds in the licensing state; or

(4) a legal nonlicensed child care provider as defined under section 119B.011, subdivision 16, providing legal child care services. A ~~legally unlicensed family~~ legal nonlicensed child care provider must be at least 18 years of age, and not a member of the MFIP assistance unit or a member of the family receiving child care assistance to be authorized under this chapter.

EFFECTIVE DATE. This section is effective September 24, 2018.

Sec. 3. Minnesota Statutes 2017 Supplement, section 119B.011, subdivision 20, is amended to read:

Subd. 20. **Transition year families.** "Transition year families" means families who have received MFIP assistance, or who were eligible to receive MFIP assistance after choosing to discontinue receipt of the cash portion of MFIP assistance under section 256J.31, subdivision 12, or families who have received DWP assistance under section 256J.95 for at least ~~three~~ one of the last six months before losing eligibility for MFIP or DWP. Notwithstanding Minnesota Rules, parts 3400.0040, subpart 10, and 3400.0090, subpart 2, transition year child care may be used to support employment, approved education or training programs, or job search that meets the requirements of section 119B.10. Transition year

child care is not available to families who have been disqualified from MFIP or DWP due to fraud.

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 4. Minnesota Statutes 2016, section 119B.02, subdivision 7, is amended to read:

Subd. 7. **Child care market rate survey.** ~~Biennially,~~ The commissioner shall conduct the next survey of prices charged by child care providers in Minnesota in state fiscal year 2021 and every three years thereafter to determine the 75th percentile for like-care arrangements in county price clusters.

Sec. 5. Minnesota Statutes 2017 Supplement, section 119B.025, subdivision 1, is amended to read:

Subdivision 1. **Applications.** (a) Except as provided in paragraph (c), clause (4), the county shall verify the following at all initial child care applications using the universal application:

(1) identity of adults;

(2) presence of the minor child in the home, if questionable;

(3) relationship of minor child to the parent, stepparent, legal guardian, eligible relative caretaker, or the spouses of any of the foregoing;

(4) age;

(5) immigration status, if related to eligibility;

(6) Social Security number, if given;

(7) counted income;

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

(9) residence; and

(10) inconsistent information, if related to eligibility.

(b) The county must mail a notice of approval or denial of assistance to the applicant within 30 calendar days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension.

(c) For an applicant who declares that the applicant is homeless and who meets the definition of homeless in section 119B.011, subdivision 13b, the county must:

(1) if information is needed to determine eligibility, send a request for information to the applicant within five working days after receiving the application;

(2) if the applicant is eligible, send a notice of approval of assistance within five working days after receiving the application;

(3) if the applicant is ineligible, send a notice of denial of assistance within 30 days after receiving the application. The county may extend the response time by 15 calendar days if the applicant is informed of the extension;

(4) not require verifications required by paragraph (a) before issuing the notice of approval or denial; and

(5) follow limits set by the commissioner for how frequently expedited application processing may be used for an applicant who declares that the applicant is homeless.

(d) An applicant who declares that the applicant is homeless must submit proof of eligibility within three months of the date the application was received. If proof of eligibility is not submitted within three months, eligibility ends. A 15-day adverse action notice is required to end eligibility.

EFFECTIVE DATE. This section is effective August 12, 2019.

Sec. 6. Minnesota Statutes 2016, section 119B.03, subdivision 9, is amended to read:

Subd. 9. **Portability pool.** (a) The commissioner shall establish a pool of up to five percent of the annual appropriation for the basic sliding fee program to provide continuous child care assistance for eligible families who move between Minnesota counties. At the end of each allocation period, any unspent funds in the portability pool must be used for assistance under the basic sliding fee program. If expenditures from the portability pool exceed the amount of money available, the reallocation pool must be reduced to cover these shortages.

(b) ~~To be eligible for portable basic sliding fee assistance,~~ A family that has moved from a county in which it was receiving basic sliding fee assistance to a county with a waiting list for the basic sliding fee program must:

(1) meet the income and eligibility guidelines for the basic sliding fee program; and

(2) notify ~~the new county of residence within 60 days of moving and submit information to the new county of residence to verify eligibility for the basic sliding fee program~~ the family's previous county of residence of the family's move to a new county of residence.

(c) The receiving county must:

(1) accept administrative responsibility for applicants for portable basic sliding fee assistance at the end of the two months of assistance under the Unitary Residency Act;

(2) continue portability pool basic sliding fee assistance ~~for the lesser of six months or~~ until the family is able to receive assistance under the county's regular basic sliding program; and

(3) notify the commissioner through the quarterly reporting process of any family that meets the criteria of the portable basic sliding fee assistance pool.

EFFECTIVE DATE. This section is effective October 8, 2018.

Sec. 7. Minnesota Statutes 2017 Supplement, section 119B.06, subdivision 1, is amended to read:

Subdivision 1. **Commissioner to administer block grant.** The commissioner is authorized and directed to receive, administer, and expend child care funds available under the child care and development block grant authorized under the Child Care and Development Block Grant Act of 2014, Public Law 113-186. From the discretionary amounts provided for federal fiscal year 2018 and reserved for quality activities, the commissioner shall ensure that funds are prioritized to increase the availability of training and business planning assistance for child care providers.

Sec. 8. Minnesota Statutes 2017 Supplement, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

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

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

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

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

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

(e) If a family has one child with a child care authorization and the child turns 13 years of age or the child has a disability and turns 15 years of age, the family remains eligible until the redetermination.

Sec. 9. Minnesota Statutes 2017 Supplement, section 119B.095, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 119B.10 for employment, education, or an MFIP or DWP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 119B.10, subdivision 3, or has an MFIP or DWP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b).

(e) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

Sec. 10. Minnesota Statutes 2017 Supplement, section 119B.13, subdivision 1, is amended to read:

Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning February 3, 2014,~~ The maximum rate paid for child care assistance in any county or county price cluster under the child care fund shall be the greater of the 25th percentile calculated by the commissioner of the ~~2011~~ most recent child care provider rate survey under section 119B.02, subdivision 7, or the ~~maximum rate effective November 28, 2011~~ rates in effect at the time of the update:

(1) for the first update on February 22, 2019, the commissioner shall determine the percentile of the most recent child care provider rate survey, not to exceed the 25th percentile, that can be funded using Minnesota's increase in federal child care and development funds appropriated in the federal Consolidated Appropriations Act of 2018, Public Law 115-141, and any subsequent federal appropriation for federal fiscal year 2019, after complying with other requirements of the reauthorization of the Child Care Development Block Grant (CCDBG) Act of 2014, enacted in state law in 2018; and

(2) beginning in fiscal year 2022, the commissioner, in consultation with the commissioner of management and budget, shall determine the amount of federal funding for child care assistance programs to use in setting maximum rates for child care programs based on the most recent market survey, not to exceed the 25th percentile, so that the cost of compliance with child care development block grant requirements enacted in state law in 2018, including the rate adjustment, are paid only with federal CCDBG funds. If federal CCDBG funds are not sufficient to maintain the enacted compliance requirements and the maximum rates in effect at the time of the rate change, the commissioner must adjust maximum rates to remain within the limits of available funds.

(b) For a child care provider located within the boundaries of a city located in two or more of the counties of Benton, Sherburne, and Stearns, the maximum rate paid for child care assistance shall be equal to the maximum rate paid in the county with the highest maximum reimbursement rates or the provider's charge, whichever is less.

(c) The commissioner may: (1) assign a county with no reported provider prices to a similar price cluster; and (2) consider county level access when determining final price clusters.

~~(b)~~ (d) A rate which includes a special needs rate paid under subdivision 3 may be in excess of the maximum rate allowed under this subdivision.

~~(c)~~ (e) The department shall monitor the effect of this paragraph on provider rates. The county shall pay the provider's full charges for every child in care up to the maximum established. The commissioner shall determine the maximum rate for each type of care on an hourly, full-day, and weekly basis, including special needs and disability care.

~~(d)~~ (f) If a child uses one provider, the maximum payment for one day of care must not exceed the daily rate. The maximum payment for one week of care must not exceed the weekly rate.

~~(e)~~ (g) If a child uses two providers under section 119B.097, the maximum payment must not exceed:

(1) the daily rate for one day of care;

(2) the weekly rate for one week of care by the child's primary provider; and

(3) two daily rates during two weeks of care by a child's secondary provider.

~~(f)~~ (h) Child care providers receiving reimbursement under this chapter must not be paid activity fees or an additional amount above the maximum rates for care provided during nonstandard hours for families receiving assistance.

~~(g)~~ (i) If the provider charge is greater than the maximum provider rate allowed, the parent is responsible for payment of the difference in the rates in addition to any family co-payment fee.

~~(h)~~ (j) All maximum provider rates changes shall be implemented on the Monday following the effective date of the maximum provider rate.

~~(i)~~ (k) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum registration fees in effect on January 1, 2013, shall remain in effect.

EFFECTIVE DATE. This section is effective February 22, 2019.

Sec. 11. Minnesota Statutes 2017 Supplement, section 245A.06, subdivision 8, is amended to read:

Subd. 8. **Requirement to post ~~correction order~~ conditional license.** ~~(a)~~ For licensed family child care providers and child care centers, upon receipt of any ~~correction order or~~ order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the ~~correction order or~~ order of conditional license by the license holder, the license holder shall post the ~~correction order or~~ order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the ~~correction order or~~ order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the investigation memoranda must be posted with the ~~correction order or~~ order of conditional license.

~~(b) If the commissioner reverses or rescinds a violation in a correction order upon reconsideration under subdivision 2, the commissioner shall issue an amended correction order and the license holder shall post the amended order according to paragraph (a).~~

~~(c) If the correction order is rescinded or reversed in full upon reconsideration under subdivision 2, the license holder shall remove the original correction order posted according to paragraph (a).~~

Sec. 12. Minnesota Statutes 2016, section 245A.175, is amended to read:

245A.175 CHILD FOSTER CARE TRAINING REQUIREMENT; MENTAL HEALTH TRAINING; FETAL ALCOHOL SPECTRUM DISORDERS TRAINING.

Prior to a nonemergency placement of a child in a foster care home, the child foster care license holder and caregivers in foster family and treatment foster care settings, and all staff providing care in foster residence settings must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches for dealing with a child's behaviors. At least one hour of the annual training requirement for the foster family license holder and caregivers, and foster residence staff must be on children's mental health issues and treatment. Except for providers and services under chapter 245D, the annual training must also include at least one hour of training on fetal alcohol spectrum disorders ~~within the first 12 months of licensure. After the first 12 months of licensure, training on fetal alcohol spectrum disorders may count~~, which must be counted toward the 12 hours of required in-service training per year. Short-term substitute caregivers are exempt from these requirements. Training curriculum shall be approved by the commissioner of human services.

Sec. 13. Minnesota Statutes 2016, section 254A.035, subdivision 2, is amended to read:

Subd. 2. **Membership terms, compensation, removal and expiration.** The membership of this council shall be composed of 17 persons who are American Indians and who are appointed by the commissioner. The commissioner shall appoint one representative from each of the following groups: Red Lake Band of Chippewa Indians; Fond du Lac Band, Minnesota Chippewa Tribe; Grand Portage Band, Minnesota Chippewa Tribe; Leech Lake Band, Minnesota Chippewa Tribe; Mille Lacs Band, Minnesota Chippewa Tribe; Bois Forte Band, Minnesota Chippewa Tribe; White Earth Band, Minnesota Chippewa Tribe; Lower Sioux Indian Reservation; Prairie Island Sioux Indian Reservation; Shakopee Mdewakanton Sioux Indian Reservation; Upper Sioux Indian Reservation; International Falls Northern Range; Duluth Urban Indian Community; and two representatives from the Minneapolis Urban Indian Community and two from the St. Paul Urban Indian Community. The terms, compensation, and removal of American Indian Advisory Council members shall be as provided in section 15.059. The council expires June 30, ~~2018~~ 2023.

Sec. 14. Minnesota Statutes 2016, section 256K.45, subdivision 2, is amended to read:

Subd. 2. **Homeless youth report.** The commissioner shall prepare a biennial report, beginning in February 2015, which provides meaningful information to the legislative committees having jurisdiction over the issue of homeless youth, that includes, but is not limited to: (1) a list of the areas of the state with the greatest need for services and housing for homeless youth, and the level and nature of the needs identified; (2) details about grants made; (3) the distribution of funds throughout the state based on population need; (4) follow-up information, if available, on the status of homeless youth and whether they have stable housing two years after services are provided; and (5) any other outcomes for populations served to determine the effectiveness of the programs and use of funding. The commissioner is exempt from preparing this report in 2019 and must instead update the 2007 report on homeless youth under section 22.

Sec. 15. Minnesota Statutes 2016, section 256M.41, subdivision 3, is amended to read:

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

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

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

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

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

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

Sec. 16. Minnesota Statutes 2016, section 256M.41, is amended by adding a subdivision to read:

Subd. 4. **County performance on child protection measures.** The commissioner shall set child protection measures and standards. The commissioner shall require an underperforming county to demonstrate that the county designated sufficient funds and implemented a reasonable strategy to improve child protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's funds under this section toward the performance improvement plan for a county not meeting child protection standards and not demonstrating significant improvement. Sanctions under section 256M.20, subdivision 3, related to noncompliance with federal performance standards also apply.

Sec. 17. Minnesota Statutes 2016, section 256N.24, is amended by adding a subdivision to read:

Subd. 2a. **Minnesota assessment of parenting for children and youth (MAPCY) revision.** The commissioner, in consultation with representatives from communities of color, including but not limited to advisory councils and ombudspersons, shall review and revise the MAPCY tool and incorporate changes that take into consideration different cultures and the diverse needs of communities of color.

Sec. 18. Minnesota Statutes 2016, section 260.835, subdivision 2, is amended to read:

Subd. 2. **Expiration.** The American Indian Child Welfare Advisory Council expires June 30, ~~2018~~ 2023.

Sec. 19. **[260C.008] FOSTER CARE SIBLING BILL OF RIGHTS.**

Subdivision 1. **Statement of rights.** (a) A child placed in foster care who has a sibling has the right to:

(1) be placed in foster care homes with the child's siblings, when possible and when it is in the best interest of each sibling, in order to sustain family relationships;

(2) be placed in close geographical distance to the child's siblings, if placement together is not possible, to facilitate frequent and meaningful contact;

(3) have frequent contact with the child's siblings in foster care and, whenever possible, with the child's siblings who are not in foster care, unless the responsible social services

agency has documented that contact is not in the best interest of any sibling. Contact includes, but is not limited to, telephone calls, text messaging, social media and other Internet use, and video calls;

(4) annually receive a telephone number, address, and e-mail address for all siblings in foster care, and receive updated photographs of siblings regularly, by regular mail or e-mail;

(5) participate in regular face-to-face visits with the child's siblings in foster care and, whenever possible, with the child's siblings who are not in foster care. Participation in these visits shall not be withheld or restricted as a consequence for behavior, and shall only be restricted if the responsible social services agency documents that the visits are contrary to the safety or well-being of any sibling. Social workers, parents, foster care providers, and older children must cooperate to ensure regular visits and must coordinate dates, times, transportation, and other accommodations as necessary. The timing and regularity of visits shall be outlined in each sibling's service plan, based on the individual circumstances and needs of each child. A social worker need not give explicit permission for each visit or possible overnight visit, but foster care providers shall communicate with social workers about these visits;

(6) be actively involved in each other's lives and share celebrations, if they choose to do so, including but not limited to birthdays, holidays, graduations, school and extracurricular activities, cultural customs in the siblings' native language, and other milestones;

(7) be promptly informed about changes in sibling placements or circumstances, including but not limited to new placements, discharge from placements, significant life events, and discharge from foster care;

(8) be included in permanency planning decisions for siblings, if appropriate; and

(9) be informed of the expectations for and possibility of continued contact with a sibling after an adoption or transfer of permanent physical and legal custody to a relative.

(b) Adult siblings of children in foster care shall have the right to be considered as foster care providers, adoptive parents, and relative custodians for their siblings, if they choose to do so.

Subd. 2. **Interpretation.** The rights under this section are established for the benefit of siblings in foster care. This statement of rights does not replace or diminish other rights, liberties, and responsibilities that may exist relative to children in foster care, adult siblings of children in foster care, foster care providers, parents, relatives, or responsible social services agencies.

Subd. 3. **Disclosure.** Child welfare agency staff shall provide a copy of these rights to a child who has a sibling at the time the child enters foster care, to any adult siblings of a child entering foster care, if known, and to the foster care provider, in a format specified by the commissioner of human services. The copy shall contain the address and telephone number of the Office of Ombudsman for Families and a brief statement describing how to file a complaint with the office.

EFFECTIVE DATE. This section is effective for children entering foster care on or after August 1, 2018. Subdivision 3 is effective August 1, 2018, and applies to all children in foster care on that date, regardless of when the child entered foster care.

Sec. 20. **[260C.81] CHILD WELFARE TRAINING SYSTEM.**

Subdivision 1. **Child welfare training system.** (a) The commissioner of human services shall modify the Child Welfare Training System developed pursuant to section 626.5591, subdivision 2, as provided in this section. The new training framework shall be known as the Child Welfare Training Academy.

(b) The Child Welfare Training Academy shall be administered through five regional hubs in northwest, northeast, southwest, southeast, and central Minnesota. Each hub shall deliver training targeted to the needs of its particular region, taking into account varying demographics, resources, and practice outcomes.

(c) The Child Welfare Training Academy shall use training methods best suited to the training content. National best practices in adult learning must be used to the greatest extent possible, including online learning methodologies, coaching, mentoring, and simulated skill application.

(d) Each child welfare worker and supervisor shall be required to complete a certification, including a competency-based knowledge test and a skills demonstration, at the completion of the worker's initial training and biennially thereafter. The commissioner shall develop ongoing training requirements and a method for tracking certifications.

(e) Each regional hub shall have a regional organizational effectiveness specialist trained in continuous quality improvement strategies. The specialist shall provide organizational change assistance to counties and tribes, with priority given to efforts intended to impact child safety.

(f) The Child Welfare Training Academy shall include training and resources that address worker well-being and secondary traumatic stress.

(g) The Child Welfare Training Academy shall serve the primary training audiences of: (1) county and tribal child welfare workers; (2) county and tribal child welfare supervisors; and (3) staff at private agencies providing out-of-home placement services for children involved in Minnesota's county and tribal child welfare system.

(h) The commissioner of human services shall enter: (1) into a partnership with the University of Minnesota to collaborate in the administration of workforce training; and (2) enter into a partnership with one or more agencies to provide consultation, subject matter expertise, and capacity building in organizational resilience and child welfare workforce well-being.

Subd. 2. **Rulemaking.** The commissioner of human services may adopt rules by December 31, 2020, as necessary to establish the Child Welfare Training Academy. If the commissioner of human services does not adopt rules by December 31, 2020, rulemaking authority under this section is repealed. Rulemaking authority under this section is not continuing authority to amend or repeal rules. Any additional action on rules after adoption must be under specific statutory authority to take the additional action.

Sec. 21. Minnesota Statutes 2016, section 626.556, is amended by adding a subdivision to read:

Subd. 17. **Child protection safety and risk-based framework response system planning initiative.** (a) The commissioner shall partner with select Minnesota counties and tribal child welfare agencies, including Hennepin County and at least one rural county, and other counties that must represent a balance around the state, to make recommendations for the creation of a safety and risk-based framework that will improve appropriate, timely, and adequate responses to a child's safety needs using a trauma-informed lens. As part of this work, the commissioner, county, and tribal child welfare agencies shall review Minnesota's child maltreatment statutes, administrative rules, guidelines, and practices, and make recommendations on modifications needed to implement a safety and risk-based framework and a response system that enhances the protection of children and best focuses county and tribal child protection resources in accordance with the risk and safety needs of children. In forming these recommendations, the commissioner shall consult with county attorneys, law enforcement, parents, attorneys representing parents, the guardian ad litem program, mental and physical health care providers, child development experts, and other stakeholders that the commissioner deems appropriate.

(b) By January 31, 2019, the commissioner shall make recommendations regarding the creation of a safety and risk-based framework to the relevant legislative committees.

Sec. 22. **2018 REPORT TO LEGISLATURE ON HOMELESS YOUTH.**

Subdivision 1. **Report development.** In lieu of the biennial homeless youth report under Minnesota Statutes, section 256K.45, subdivision 2, the commissioner of human services shall update the information in the 2007 legislative report on runaway and homeless youth. In developing the updated report, the commissioner may use existing data, studies, and analysis provided by state, county, and other entities including, but not limited to:

(1) Minnesota Housing Finance Agency analysis on housing availability;

(2) Minnesota state plan to end homelessness;

(3) continuum of care counts of youth experiencing homelessness and assessments as provided by Department of Housing and Urban Development (HUD)-required coordinated entry systems;

(4) data collected through the Department of Human Services Homeless Youth Act grant program;

(5) Wilder Research homeless study;

(6) Voices of Youth Count sponsored by Hennepin County; and

(7) privately funded analysis, including:

(i) nine evidence-based principles to support youth in overcoming homelessness;

(ii) return on investment analysis conducted for YouthLink by Foldes Consulting; and

(iii) evaluation of Homeless Youth Act resources conducted by Rainbow Research.

Subd. 2. **Key elements; due date.** (a) The report may include three key elements where significant learning has occurred in the state since the 2007 report, including:

(1) unique causes of youth homelessness;

(2) targeted responses to youth homelessness, including significance of positive youth development as fundamental to each targeted response; and

(3) recommendations based on existing reports and analysis on what it will take to end youth homelessness.

(b) To the extent data is available, the report must include:

(1) general accounting of the federal and philanthropic funds leveraged to support homeless youth activities;

(2) general accounting of the increase in volunteer responses to support youth experiencing homelessness; and

(3) data-driven accounting of geographic areas or distinct populations that have gaps in service or are not yet served by homeless youth responses.

(c) The commissioner of human services may consult with community-based providers of homeless youth services and other expert stakeholders to complete the report. The commissioner shall submit the report to the chairs and ranking minority members of the legislative committees with jurisdiction over youth homelessness by February 15, 2019.

Sec. 23. **AFRICAN AMERICAN CHILD WELFARE WORK GROUP.**

The commissioner of human services shall form an African American child welfare work group within the implementation work group for the Governor's Child Protection Task Force to help formulate policies and procedures relating to African American child welfare services and to ensure that African American families are provided with all possible services and opportunities to care for their children in their homes. The work group shall include child welfare policy and social work professionals and paraprofessionals, community members, community leaders, and parents representing all regions of the state. By February 1, 2019, the work group shall report its findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over child protection issues.

Sec. 24. **REVIEW OF BACKGROUND STUDIES AND LICENSING PROCESSES FOR RELATIVE FOSTER CARE.**

(a) The commissioner shall work with six counties, which must include Hennepin County, at least one rural county, and other counties that must represent a balance around the state, to review the background study and licensing processes for relative child foster care. The review must analyze past reports on foster care, licensing data, barriers to timely licensure for relatives, child safety, well-being, and permanency outcomes of children placed in foster care with relatives.

(b) By January 31, 2019, the commissioner shall make recommendations for improving the background study and licensing processes for children placed in foster care with relatives to the relevant legislative committees.

Sec. 25. **DEPARTMENT OF LICENSING, BACKGROUND STUDIES, AND OVERSIGHT.**

(a) It is the goal of the legislature to consolidate into one new state agency the licensing, background study, and related oversight functions currently in the Department of Human Services and Department of Health, including the Office of Inspector General, the Minnesota Adult Abuse Reporting Center (MAARC), and the Office of Health Facility Complaints (OHFC).

(b) The commissioners of human services and health shall work with the revisor of statutes to draft legislation establishing the new state agency, and provide the legislation to the chairs and ranking minority members of the senate and house of representatives committees with jurisdiction over health and human services by December 15, 2018, with the goal of the new state agency to begin operations on July 1, 2019.

ARTICLE 2

STATE-OPERATED SERVICES; CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2017 Supplement, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 124D.23 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with severe emotional disturbances who are at risk of out-of-home placement;

(4) children's mental health crisis services;

(5) mental health services for people from cultural and ethnic minorities;

(6) children's mental health screening and follow-up diagnostic assessment and treatment;

(7) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(8) school-linked mental health services~~, including transportation for children receiving school-linked mental health services when school is not in session~~;

(9) building evidence-based mental health intervention capacity for children birth to age five;

(10) suicide prevention and counseling services that use text messaging statewide;

(11) mental health first aid training;

(12) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive Web site to share information and strategies to promote resilience and prevent trauma;

(13) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(14) early childhood mental health consultation;

(15) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(16) psychiatric consultation for primary care practitioners; and

(17) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee must obtain all available third-party reimbursement sources, if applicable.

Sec. 2. Minnesota Statutes 2016, section 245.4889, is amended by adding a subdivision to read:

Subd. 1a. **School-linked mental health services grants.** (a) An eligible applicant for school-linked mental health services grants under subdivision 1, paragraph (b), clause (8), is an entity that is:

(1) certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or facility owned and operated by a tribe or tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943; or

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals as defined in section 245.4871, subdivision 27, clauses (1) to (6), or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families.

(b) Allowable grant expenses include transportation for children receiving school-linked mental health services when school is not in session, and may be used to purchase equipment, connection charges, set-up fees, and site fees in order to deliver school-linked mental health services defined in subdivision 1a, via telemedicine consistent with section 256B.0625, subdivision 3b.

Sec. 3. **[246.0415] PLACEMENT OF CLIENTS WHO EXHIBIT ASSAULTIVE OR VIOLENT BEHAVIOR.**

Clients who exhibit assaultive or violent behavior, have severe behavior issues, or are involved with or are at risk of being involved with the criminal justice system must be placed in or moved to a setting that meets the client's needs and ensures the safety of the public. The commissioner shall balance the needs of the client to live in the most integrated setting with public safety. The commissioner shall provide an appropriate placement for clients who have a medium or high risk for committing violent acts, and clients must not be placed in a residential setting that jeopardizes the safety of others until the commissioner determines that the client is low risk for committing violent acts.

Sec. 4. Minnesota Statutes 2016, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency treatment appropriation shall be placed in a special revenue account. ~~The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated.~~ The ~~remainder of the~~ money in the special revenue account must be used according to the requirements in this chapter.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 5. Minnesota Statutes 2016, section 254B.06, subdivision 1, is amended to read:

Subdivision 1. **State collections.** The commissioner is responsible for all collections from persons determined to be partially responsible for the cost of care of an eligible person receiving services under Laws 1986, chapter 394, sections 8 to 20. The commissioner may initiate, or request the attorney general to initiate, necessary civil action to recover the unpaid cost of care. The commissioner may collect all third-party payments for chemical dependency services provided under Laws 1986, chapter 394, sections 8 to 20, including private insurance and federal Medicaid and Medicare financial participation. ~~The commissioner shall deposit in a dedicated account a percentage of collections to pay for the cost of operating the chemical dependency consolidated treatment fund invoice processing and vendor payment system, billing, and collections.~~ The ~~remaining~~ receipts must be deposited in the chemical dependency fund.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 6. **PERSON-CENTERED TELEPRESENCE PLATFORM EXPANSION WORK GROUP.**

Subdivision 1. **Membership.** (a) The commissioner of human services shall convene a work group for the purpose of exploring opportunities to collaborate and expand strategies for person-centered innovation using Internet telepresence in delivering health and human services, as well as related educational and correctional services. The commissioner, in consultation with the commissioner of health, shall appoint the following members:

(1) three members representing county services in the areas of human services, health, and corrections or law enforcement. These members must represent counties outside the metropolitan area defined in Minnesota Statutes, section 473.121;

(2) one member representing public health;

(3) one member recommended by the Minnesota American Indian Mental Health Advisory Council;

(4) one member recommended by the Minnesota Medical Association who is a primary care provider practicing in outstate Minnesota;

(5) one member recommended by NAMI of Minnesota;

(6) two members recommended by the Minnesota School Boards Association;

(7) one member recommended by the Minnesota Hospital Association representing rural hospital emergency departments;

(8) one member representing community mental health centers;

(9) one member representing adolescent treatment centers;

(10) one member representing child advocacy centers; and

(11) one member recommended by the chief justice of the Supreme Court representing the judicial system.

(b) In addition to the members identified in paragraph (a), the work group shall include:

(1) the commissioner of MN.IT services or a designee;

(2) the commissioner of corrections or a designee;

(3) the commissioner of health or a designee; and

(4) the commissioner of education or a designee.

Subd. 2. **First meeting; chair.** The commissioner shall serve as the chair, and make appointments and convene the first meeting of the work group by September 1, 2018.

Subd. 3. **Duties.** The work group shall:

(1) explore opportunities for improving behavioral health and other health care service delivery through the use of a common interoperable person-centered telepresence platform that provides connectivity and technical support to potential users;

(2) review and coordinate state and local innovation initiatives and investments designed to leverage telepresence connectivity and collaboration;

(3) identify standards and capabilities for a single interoperable telepresence platform;

(4) identify barriers to providing a telepresence technology, including limited availability of bandwidth, limitations in providing certain services via telepresence, and broadband infrastructure needs;

(5) identify and make recommendations for governance to assure person-centered responsiveness;

(6) identify how the business model itself can be innovated to provide an incentive for ongoing innovation in Minnesota's health and human service ecosystems;

(7) evaluate and make recommendations for a potential vendor that could provide a single telepresence platform in terms of delivering the identified standards and capabilities;

(8) identify sustainable financial support for a single telepresence platform, including infrastructure costs and start-up costs for potential users; and

(9) identify the benefits to the state, political subdivisions, and tribal governments, and the constituents they serve in using a common person-centered telepresence platform for delivering behavioral health services.

Subd. 4. **Report.** The commissioner shall report to the chairs and ranking minority members of the committees in the senate and the house of representatives with primary jurisdiction over health and state information technology by January 15, 2019, with recommendations related to expanding the state's telepresence platform and any legislation required to implement the recommendations.

Subd. 5. **Expiration.** The work group expires January 16, 2019.

ARTICLE 3

COMMUNITY SUPPORTS AND CONTINUING CARE

Section 1. Minnesota Statutes 2017 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section

245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care;

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services;

(6) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from the residential care waiver services to foster care services. This exception applies only when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service to help the person make an informed choice; and

(ii) the person's foster care services are less than or equal to the cost of the person's services delivered in the residential care waiver service setting as determined by the lead agency; ~~or~~

(7) new foster care licenses or community residential setting licenses for people receiving services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and for which a license is required. This exception does not apply to people living in their own home. For purposes of this clause, there is a presumption that a foster care or community residential setting license is required for services provided to three or more people in a dwelling unit when the setting is controlled by the provider. A license holder subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, ~~2018~~ 2019. This exception is available when:

(i) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(ii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the unlicensed setting as determined by the lead agency~~.~~; or

(8) a vacancy in a setting granted an exception under clause (7), created between January 1, 2017, and the date of the exception request, by the departure of a person receiving services under chapter 245D and residing in the unlicensed setting between January 1, 2017, and May 1, 2017. This exception is available when the lead agency provides documentation to the commissioner on the eligibility criteria being met. This exception is available until June 30, 2019.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department may decrease the statewide licensed capacity for adult foster care settings.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity determined under section 256B.493 will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet the informed decisions of those people who want to move out of corporate foster care or community residential settings, long-term service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term services and supports reports and statewide data and information.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493. Annually, by August 1, the commissioner shall provide information and data on capacity of licensed long-term services and supports, actions taken under the subdivision to manage statewide long-term services and supports resources, and

any recommendations for change to the legislative committees with jurisdiction over the health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

EFFECTIVE DATE. This section is effective June 29, 2018.

Sec. 2. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (g).

(b) The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a facility with a licensed capacity of up to five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(d) The commissioner may grant variances to paragraph (a) to allow the use of an additional bed, up to five, for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of an additional bed, up to five, for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed facility is located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the facility; and

(4) individuals living in the facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing

agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before ~~March 1, 2011~~ June 30, 2016.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, ~~2019~~ 2021. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, ~~2019~~ 2021, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 3. Minnesota Statutes 2017 Supplement, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disability, and elderly waiver plans, excluding

out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; and

(7) individual community living support under section 256B.0915, subdivision 3j.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) ~~behavioral~~ positive support services as defined under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans; and

(iii) specialist services as defined under the current brain injury, community access for disability inclusion, community alternative care, and developmental disability waiver ~~plan~~ plans;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community access for disability inclusion waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans; and

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disability waiver plans.

Sec. 4. Minnesota Statutes 2016, section 245D.071, subdivision 5, is amended to read:

Subd. 5. **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. At least once per year, or within 30 days of a written request by the person, the person's legal representative, or the case manager, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum ~~or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year~~. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) At least once per year, the license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager to discuss how technology might be used to meet the person's desired outcomes. The coordinated service and support plan or support plan addendum must include a summary of this discussion. The summary must include a statement regarding any decision made related to the use of technology and a description of any further research that must be completed before a decision regarding the use of technology can be made. Nothing in this paragraph requires the coordinated service and support plan to include the use of technology for the provision of services.

~~(b)~~ (c) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a report available at the time of the progress review meeting. The report

must be sent at least five working days prior to the progress review meeting if requested by the team in the coordinated service and support plan or coordinated service and support plan addendum.

~~(c)~~ (d) The license holder must send the coordinated service and support plan addendum to the person, the person's legal representative, and the case manager by mail within ten working days of the progress review meeting. Within ten working days of the mailing of the coordinated service and support plan addendum, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

~~(d)~~ (e) If, within ten working days of submitting changes to the coordinated service and support plan and coordinated service and support plan addendum, the person or the person's legal representative or case manager has not signed and returned to the license holder the coordinated service and support plan or coordinated service and support plan addendum or has not proposed written modifications to the license holder's submission, the submission is deemed approved and the coordinated service and support plan addendum becomes effective and remains in effect until the legal representative or case manager submits a written request to revise the coordinated service and support plan addendum.

Sec. 5. Minnesota Statutes 2016, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **~~Behavior~~ Positive support professional qualifications.** A ~~behavior~~ positive support professional providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); ~~or~~

(vi) person with a master's degree or PhD in one of the behavioral sciences or related fields with demonstrated expertise in positive support services; or

(vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 6. Minnesota Statutes 2016, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **~~Behavior~~ Positive support analyst qualifications.** (a) A ~~behavior~~ positive support analyst providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; ~~or~~

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17~~.~~; or

(3) be a board certified behavior analyst or board certified assistant behavior analyst by the Behavior Analyst Certification Board, Incorporated.

(b) In addition, a ~~behavior~~ positive support analyst must:

(1) have four years of supervised experience ~~working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder~~ conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for people who exhibit challenging behaviors as well as co-occurring mental disorders and neurocognitive disorder;

(2) have received ~~ten hours of instruction in functional assessment and functional analysis;~~ training prior to hire or within 90 calendar days of hire that includes:

(i) ten hours of instruction in functional assessment and functional analysis;

(ii) 20 hours of instruction in the understanding of the function of behavior;

(iii) ten hours of instruction on design of positive practices behavior support strategies;

(iv) 20 hours of instruction preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing and reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in implementation fidelity, and recommending enhancements based on evaluation data; and

(v) eight hours of instruction on principles of person-centered thinking;

~~(3) have received 20 hours of instruction in the understanding of the function of behavior;~~

~~(4) have received ten hours of instruction on design of positive practices behavior support strategies;~~

~~(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;~~

~~(6)~~ (3) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives ~~behavioral~~ positive support; and

~~(7)~~ (4) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraph (b).

Sec. 7. Minnesota Statutes 2016, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **~~Behavior~~ Positive support specialist qualifications.** (a) A ~~behavior~~ positive support specialist providing ~~behavioral~~ positive support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), must have competencies in the following areas as required under the brain injury ~~and~~, community access for disability inclusion, community alternative care, and developmental disability waiver plans or successor plans:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received training prior to hire or within 90 calendar days of hire that includes:

(i) a minimum of four hours of training in functional assessment;

~~(2) have received~~ (ii) 20 hours of instruction in the understanding of the function of behavior;

~~(3) have received~~ (iii) ten hours of instruction on design of positive practices behavioral support strategies; and

(iv) eight hours of instruction on principles of person-centered thinking;

~~(4)~~ (2) be determined by a ~~behavior~~ positive support professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior

reduction approved intervention to the person who receives ~~behavioral~~ positive support; and

~~(5)~~ (3) be under the direct supervision of a ~~behavior~~ positive support professional.

(c) Meeting the qualifications for a positive support professional under subdivision 2 shall substitute for meeting the qualifications listed in paragraphs (a) and (b).

Sec. 8. Minnesota Statutes 2016, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. During the transition to MnCHOICES, a certified assessor may complete the assessment defined in this subdivision. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the

commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Sec. 9. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

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

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient; and

(10) be limited to providing and being paid for up to 275 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents, stepparents, and legal guardians of minors; spouses; paid legal guardians of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of a residential setting.

(d) Personal care services qualify for the enhanced rate described in subdivision 17a if the personal care assistant providing the services:

(1) provides services, according to the care plan in subdivision 7, to a recipient who qualifies for 12 or more hours per day of PCA services; and

(2) satisfies the current requirements of Medicare for training and competency or competency evaluation of home health aides or nursing assistants, as provided in the Code of Federal Regulations, title 42, section 483.151 or 484.36, or alternative state approved training or competency requirements.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 10. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision to read:

Subd. 17a. **Enhanced rate.** An enhanced rate of 105 percent of the rate paid for PCA services shall be paid for services provided to persons who qualify for 12 or more hours of PCA service per day when provided by a PCA who meets the requirements of subdivision 11, paragraph (d). The enhanced rate for PCA services includes, and is not in addition to, any rate adjustments implemented by the commissioner on July 1, 2018, to comply with the terms of a collective bargaining agreement between the state of Minnesota and an exclusive representative of individual providers under section 179A.54 that provides for wage increases for individual providers who serve participants assessed to need 12 or more hours of PCA services per day.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 11. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

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

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

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

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

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

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section, including the requirements under subdivision 11, paragraph (d), if enhanced PCA services are provided and submitted for an enhanced rate under subdivision 17a;

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

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

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

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or

for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

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

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

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 12. Minnesota Statutes 2016, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

(15) document that the agency uses the additional revenue due to the enhanced rate under subdivision 17a for the wages and benefits of the PCAs whose services meet the requirements under subdivision 11, paragraph (d).

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 13. Minnesota Statutes 2016, section 256B.0659, subdivision 28, is amended to read:

Subd. 28. **Personal care assistance provider agency; required documentation.** (a) Required documentation must be completed and kept in the personal care assistance provider agency file or the recipient's home residence. The required documentation consists of:

(1) employee files, including:

(i) applications for employment;

(ii) background study requests and results;

(iii) orientation records about the agency policies;

(iv) trainings completed with demonstration of competence, including verification of the completion of training required under subdivision 11, paragraph (d), for any billing of the enhanced rate under subdivision 17a;

(v) supervisory visits;

(vi) evaluations of employment; and

(vii) signature on fraud statement;

(2) recipient files, including:

(i) demographics;

(ii) emergency contact information and emergency backup plan;

(iii) personal care assistance service plan;

(iv) personal care assistance care plan;

(v) month-to-month service use plan;

(vi) all communication records;

(vii) start of service information, including the written agreement with recipient; and

(viii) date the home care bill of rights was given to the recipient;

(3) agency policy manual, including:

(i) policies for employment and termination;

(ii) grievance policies with resolution of consumer grievances;

(iii) staff and consumer safety;

(iv) staff misconduct; and

(v) staff hiring, service delivery, staff and consumer safety, staff misconduct, and resolution of consumer grievances;

(4) time sheets for each personal care assistant along with completed activity sheets for each recipient served; and

(5) agency marketing and advertising materials and documentation of marketing activities and costs.

(b) The commissioner may assess a fine of up to $500 on provider agencies that do not consistently comply with the requirements of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 14. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

(1) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

(2) providing recommendations for and referrals to cost-effective community services that are available to the individual;

(3) development of an individual's person-centered community support plan;

(4) providing information regarding eligibility for Minnesota health care programs;

(5) face-to-face long-term care consultation assessments, which may be completed in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DDs), regional treatment centers, or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

(7) providing recommendations for institutional placement when there are no cost-effective community services available;

(8) providing access to assistance to transition people back to community settings after institutional admission; and

(9) providing information about competitive employment, with or without supports, for school-age youth and working-age adults and referrals to the Disability Linkage Line and Disability Benefits 101 to ensure that an informed choice about competitive employment can be made. For the purposes of this subdivision, "competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting, and for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c, and 3a, "long-term care consultation services" also means:

(1) service eligibility determination for state plan ~~home care~~ services identified in:

(i) section 256B.0625, subdivisions ~~7,~~ 19a~~,~~ and 19c;

(ii) consumer support grants under section 256.476; or

(iii) section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, determination of eligibility for case management services available under sections 256B.0621, subdivision 2, ~~paragraph~~ clause (4), and 256B.0924 ~~and Minnesota Rules, part 9525.0016~~;

(3) determination of institutional level of care, home and community-based service waiver, and other service eligibility as required under section 256B.092, ~~determination of eligibility for family support grants under section 252.32,~~ semi-independent living services under section 252.275, and day training and habilitation services under section 256B.092; ~~and~~

(4) obtaining necessary diagnostic information to determine eligibility under clauses (2) and (3); and

(5) notwithstanding Minnesota Rules, parts 9525.0004 to 9525.0024, initial eligibility determination for case management services available under Minnesota Rules, part 9525.0016.

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also

includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

(d) "Minnesota health care programs" means the medical assistance program under this chapter and the alternative care program under section 256B.0913.

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this section, "informed choice" means a voluntary choice of services by a person from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person to empower the person to make decisions.

Sec. 15. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services ~~and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement~~. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, conversation-based, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and

social needs of the individual necessary to develop a community support plan that meets the individual's needs and preferences.

(d) The assessment must be conducted in a face-to-face conversational interview with the person being assessed ~~and~~. The person's legal representative must provide input during the assessment process and may do so remotely if requested. At the request of the person, other individuals may participate in the assessment to provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety. Except for legal representatives or family members invited by the person, persons participating in the assessment may not be a provider of service or have any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living or adult day services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs prepared by a direct service employee with at least 20 hours of service to that client. The person conducting the assessment or reassessment must notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment and the person or the person's legal representative, and must be considered prior to the finalization of the assessment or reassessment.

(e) The person or the person's legal representative must be provided with a written community support plan within ~~40 calendar days of the assessment visit~~ the timelines established by the commissioner, regardless of whether the individual is eligible for Minnesota health care programs. The timeline for completing the community support plan and any required coordinated service and support plan must not exceed 56 calendar days from the assessment visit.

(f) For a person being assessed for elderly waiver services under section 256B.0915, a provider who submitted information under paragraph (d) shall receive the final written community support plan when available and the Residential Services Workbook.

(g) The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers, including service provided in a non-disability-specific setting;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d).

(j) The lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects

nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (6), and (b);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 4e and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (6), and (b); and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and (8), and (b), and incorporating the decision regarding the need for institutional level of care or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated.

(k) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, developmental disabilities, community access for disability inclusion, community alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of

state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

(m) If an eligibility update is completed within 90 days of the previous face-to-face assessment and documented in the department's Medicaid Management Information System (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a) Prior to a face-to-face reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances. Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments ~~allow for~~ require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan. Reassessments verify continued eligibility or offer alternatives as warranted and provide an opportunity for quality assurance of service delivery. Face-to-face ~~assessments~~ reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan within the timelines established by the commissioner.

(b) The commissioner shall develop mechanisms for providers and case managers to share information with the assessor to facilitate a reassessment and support planning process tailored to the person's current needs and preferences.

Sec. 17. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 5, is amended to read:

Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes, including timelines for when assessments need to be completed, required to provide the services in this section and shall implement integrated solutions to automate the business processes to the extent necessary for community support plan approval, reimbursement, program planning, evaluation, and policy development.

(b) The commissioner of human services shall work with lead agencies responsible for conducting long-term consultation services to modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

(c) The commissioner shall work with lead agencies responsible for conducting long-term consultation services to develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency. The commissioner shall collect data on these benchmarks and provide to the lead agencies and the chairs and ranking minority members of the legislative committees with jurisdiction over human services an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 18. Minnesota Statutes 2016, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of coordinated service and support plan.** (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 56 calendar days from the assessment visit;

(2) includes the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources;

(8) includes information about the right to appeal decisions under section 256.045; and

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 19. Minnesota Statutes 2016, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan ~~which~~ that:

(1) is developed with and signed by the recipient within ~~ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 56 calendar days from the assessment visit;

(2) includes the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and welfare of the recipient;

(4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

(6) identifies long-range and short-range goals for the person;

(7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The coordinated service and support plan shall also specify other services the person needs that are not available;

(8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(9) identifies provider responsibilities to implement and make recommendations for modification to the coordinated service and support plan;

(10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

(11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative;

(12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services; and

(13) includes the authorized annual and monthly amounts for the services.

(b) In developing the coordinated service and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must

be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

(c) Approved, written, and signed changes to a consumer's services that meet the criteria in this subdivision shall be an addendum to that consumer's individual service plan.

Sec. 20. Minnesota Statutes 2016, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of coordinated service and support plan.** (a) Unless otherwise required by federal law, the county agency is not required to complete a coordinated service and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

(b) Unless otherwise required by federal law, the county agency is not required to conduct or arrange for an annual needs reassessment by a certified assessor. The case manager who works on behalf of the person to identify the person's needs and to minimize the impact of the disability on the person's life must develop a person-centered service plan based on the person's assessed needs and preferences. The person-centered service plan must be reviewed annually. This paragraph applies to persons with developmental disabilities who are receiving case management services under Minnesota Rules, part 9525.0036, and who make an informed choice to decline an assessment under section 256B.0911.

Sec. 21. Minnesota Statutes 2017 Supplement, section 256B.49, subdivision 13, is amended to read:

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

(1) finalizing the written coordinated service and support plan within ~~ten working days after the case manager receives the plan from the certified assessor~~ the timelines established by the commissioner. The timeline for completing the community support plan under section 256B.0911, subdivision 3a, and the coordinated service and support plan must not exceed 56 calendar days from the assessment visit;

(2) informing the recipient or the recipient's legal guardian or conservator of service options;

(3) assisting the recipient in the identification of potential service providers and available options for case management service and providers, including services provided in a non-disability-specific setting;

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

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

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

(1) finalizing the coordinated service and support plan;

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

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

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

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

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

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

Sec. 22. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates that delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Direct care staff" means employees providing direct service provision to people receiving services under this section. Direct care staff does not include executive, managerial, and administrative staff.

(f) "Disability waiver rates system" means a statewide system that establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

~~(f)~~ (g) "Individual staffing" means the time spent as a one-to-one interaction specific to an individual recipient by staff to provide direct support and assistance with activities of daily living, instrumental activities of daily living, and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's needs must also be considered.

~~(g)~~ (h) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

~~(h)~~ (i) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

~~(i)~~ (j) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

~~(j)~~ (k) "Rates management system" means a Web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

~~(k)~~ (l) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

~~(l)~~ (m) "Shared staffing" means time spent by employees, not defined under paragraph ~~(f)~~ (g), providing or available to provide more than one individual with direct support and assistance with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (b); instrumental activities of daily living as defined under section 256B.0659, subdivision 1, paragraph (i); ancillary activities needed to support individual services; and training to participants, and is based on the requirements in each individual's coordinated service and support plan under section 245D.02, subdivision 4b; any coordinated service and support plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider observation of an individual's service need. Total shared staffing hours are divided proportionally by the number of individuals who receive the shared service provisions.

~~(m)~~ (n) "Staffing ratio" means the number of recipients a service provider employee supports during a unit of service based on a uniform assessment tool, provider observation, case history, and the recipient's services of choice, and not based on the staffing ratios under section 245D.31.

~~(n)~~ (o) "Unit of service" means the following:

(1) for residential support services under subdivision 6, a unit of service is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day;

(2) for day services under subdivision 7:

(i) for day training and habilitation services, a unit of service is either:

(A) a day unit of service is defined as six or more hours of time spent providing direct services and transportation; or

(B) a partial day unit of service is defined as fewer than six hours of time spent providing direct services and transportation; and

(C) for new day service recipients after January 1, 2014, 15 minute units of service must be used for fewer than six hours of time spent providing direct services and transportation;

(ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A day unit of service is six or more hours of time spent providing direct services;

(iii) for prevocational services, a unit of service is a day or an hour. A day unit of service is six or more hours of time spent providing direct service;

(3) for unit-based services with programming under subdivision 8:

(i) for supported living services, a unit of service is a day or 15 minutes. When a day rate is authorized, any portion of a calendar day where an individual receives services is billable as a day; and

(ii) for all other services, a unit of service is 15 minutes; and

(4) for unit-based services without programming under subdivision 9, a unit of service is 15 minutes.

Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

~~(4) behavioral programming;~~

~~(5)~~ (4) companion services;

~~(6)~~ (5) customized living;

~~(7)~~ (6) day training and habilitation;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

~~(8)~~ (10) housing access coordination;

~~(9)~~ (11) independent living skills;

(12) independent living skills specialist services;

(13) individualized home supports;

~~(10)~~ (14) in-home family support;

~~(11)~~ (15) night supervision;

~~(12)~~ (16) personal support;

(17) positive support service;

~~(13)~~ (18) prevocational services;

~~(14)~~ (19) residential care services;

~~(15)~~ (20) residential support services;

~~(16)~~ (21) respite services;

~~(17)~~ (22) structured day services;

~~(18)~~ (23) supported employment services;

~~(19)~~ (24) supported living services;

~~(20)~~ (25) transportation services;

~~(21) individualized home supports;~~

~~(22) independent living skills specialist services;~~

~~(23) employment exploration services;~~

~~(24) employment development services;~~

~~(25) employment support services;~~ and

(26) other services as approved by the federal government in the state home and community-based services plan.

Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 4, is amended to read:

Subd. 4. **Data collection for rate determination.** (a) Rates for applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set by the rates management system.

(b) Data for services under section 256B.4913, subdivision 4a, shall be collected in a manner prescribed by the commissioner.

(c) Data and information in the rates management system may be used to calculate an individual's rate.

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

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

(6) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(7) shared or individualized arrangements for unit-based services, including the staffing ratio;

(8) number of trips and miles for transportation services; and

(9) service hours provided through monitoring technology.

(e) Updates to individual data must include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

(f) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6, 7, 8, and 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead

agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

(1) meeting the health and welfare needs of the individual or individuals receiving services by service site, identified in their coordinated service and support plan under section 245D.02, subdivision 4b, and any addendum under section 245D.02, subdivision 4c;

(2) meeting the requirements for staffing under subdivision 2, paragraphs ~~(f)~~ (g), ~~(i)~~ (m), and ~~(m)~~ (n); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

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

Sec. 25. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 5, is amended to read:

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the most recent edition of the Occupational Handbook must be used. The base wage index must be calculated as follows:

(1) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing assistant (SOC code 31-1014); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for day services, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential asleep-overnight staff, the wage is the minimum wage in Minnesota for large employers, except in a family foster care setting, the wage is 36 percent of the minimum wage in Minnesota for large employers;

(4) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(5) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(6) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(7) for supportive living services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for housing access coordination staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099);

(9) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(10) for individualized home supports services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for independent living skills specialist staff, 100 percent of mental health and substance abuse social worker (SOC code 21-1023);

(13) for supported employment staff, 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code

29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(14) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment exploration services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(17) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(18) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing assistant (SOC code 31-1014); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(19) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(20) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing assistant (SOC code 31-1014);

(21) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of behavior professional, behavior analyst, and behavior specialists, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(22) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141); and

(23) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061).

(b) Component values for residential support services are:

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

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

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

(4) general administrative support ratio: 13.25 percent;

(5) program-related expense ratio: 1.3 percent; and

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

(c) Component values for family foster care are:

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

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

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

(4) general administrative support ratio: 3.3 percent;

(5) program-related expense ratio: 1.3 percent; and

(6) absence factor: 1.7 percent.

(d) Component values for day services for all services are:

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

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

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

(4) program plan support ratio: 5.6 percent;

(5) client programming and support ratio: ten percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 1.8 percent; and

(8) absence and utilization factor ratio: 9.4 percent.

(e) Component values for unit-based services with programming are:

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

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

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

(4) program plan supports ratio: 15.5 percent;

(5) client programming and supports ratio: 4.7 percent;

(6) general administrative support ratio: 13.25 percent;

(7) program-related expense ratio: 6.1 percent; and

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

(f) Component values for unit-based services without programming except respite are:

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

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

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

(4) program plan support ratio: 7.0 percent;

(5) client programming and support ratio: 2.3 percent;

(6) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

(4) general administrative support ratio: 13.25 percent;

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

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

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. On July 1, 2022, and every five years thereafter, the commissioner shall update the base wage index in paragraph (a) based on the most recently available wage data by SOC from the Bureau of Labor Statistics. The commissioner shall publish these updated values and load them into the rate management system.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner will adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rate management system. On July 1, 2022, and every five years thereafter, the commissioner shall update the framework components in paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower by the percentage change in the CPI-U from the date of the previous update to the date of the data most recently available prior to the scheduled update. The commissioner shall publish these updated values and load them into the rate management system.

(j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer Price Index items are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace missing component values.

(k) The commissioner shall increase the updated base wage index in paragraph (h) with a competitive workforce factor as follows:

(1) effective January 1, 2019, the competitive workforce factor is 8.35 percent;

(2) effective July 1, 2019, the competitive workforce factor is decreased to 5.5 percent; and

(3) effective July 1, 2020, the competitive workforce factor is decreased to 1.8 percent.

The lead agencies must implement changes to the competitive workforce factor on the dates listed in clauses (1) to (3), and not as reassessments and reauthorizations occur.

EFFECTIVE DATE. This section is effective January 1, 2019, or upon federal approval, whichever occurs later. The commissioner shall inform the revisor of statutes when federal approval is obtained.

Sec. 26. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Updating payment values and additional information.** (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

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

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

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

(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision 4a. The commissioner shall issue the first report by October 1, 2014, and the final report shall be issued by December 31, 2018.

(d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall begin the review and evaluation of the following values already in subdivisions 6 to 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

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

(3) values for indirect services;

(4) values for nursing;

(5) values for the facility use rate in day services, and the weightings used in the day service ratios and adjustments to those weightings;

(6) values for workers' compensation as part of employee-related expenses;

(7) values for unemployment insurance as part of employee-related expenses;

(8) any changes in state or federal law with a direct impact on the underlying cost of providing home and community-based services; ~~and~~

(9) direct care staff labor market measures; and

(10) outcome measures, determined by the commissioner, for home and community-based services rates determined under this section.

(e) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (b) to (d), and subdivision 10, paragraph (g), clause (6), on the following dates:

(1) January 15, 2015, with preliminary results and data;

(2) January 15, 2016, with a status implementation update, and additional data and summary information;

(3) January 15, 2017, with the full report; and

(4) January 15, 2020, with another full report, and a full report once every four years thereafter.

(f) The commissioner shall implement a regional adjustment factor to all rate calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July 1, 2017, the commissioner shall renew analysis and implement changes to the regional adjustment factors when adjustments required under subdivision 5, paragraph (h), occur. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

(g) The commissioner shall provide a public notice via LISTSERV in October of each year beginning October 1, 2014, containing information detailing legislatively approved changes in:

(1) calculation values including derived wage rates and related employee and administrative factors;

(2) service utilization;

(3) county and tribal allocation changes; and

(4) information on adjustments made to calculation values and the timing of those adjustments.

The information in this notice must be effective January 1 of the following year.

(h) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential services after January 1, 2014,

or insufficient to meet the needs of an individual with a service agreement adjustment described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours shall be used.

(i) The commissioner shall study the underlying cost of absence and utilization for day services. Based on the commissioner's evaluation of the data collected under this paragraph, the commissioner shall make recommendations to the legislature by January 15, 2018, for changes, if any, to the absence and utilization factor ratio component value for day services.

(j) Beginning July 1, 2017, the commissioner shall collect transportation and trip information for all day services through the rates management system.

Sec. 27. Minnesota Statutes 2017 Supplement, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

(5) vacation, sick, and training time paid;

(6) taxes, workers' compensation, and unemployment insurance costs paid;

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

(11) other data relating to costs required to provide services requested by the commissioner.

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services every four years beginning January 1, 2020. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(e) The commissioner, in consultation with stakeholders identified in section 256B.4913, subdivision 5, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

(f) Beginning January 1, 2019, providers enrolled to provide services with rates determined under this section shall submit labor market data to the commissioner annually.

(g) Beginning January 15, 2020, the commissioner shall publish annual reports on provider and state-level labor market data, including, but not limited to:

(1) number of direct care staff;

(2) wages of direct care staff;

(3) benefits provided to direct care staff;

(4) direct care staff job vacancies;

(5) direct care staff retention rates; and

(6) an evaluation of the effectiveness of the competitive workforce factors.

Sec. 28. Minnesota Statutes 2017 Supplement, section 256I.03, subdivision 8, is amended to read:

Subd. 8. **Supplementary services.** "Supplementary services" means housing support services provided to individuals in addition to room and board including, but not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services. Providers must comply with section 256I.04, subdivision 2h.

Sec. 29. Minnesota Statutes 2017 Supplement, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Housing support agreements.** (a) Agreements between agencies and providers of housing support must be in writing on a form developed and approved by the commissioner and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from housing support funds for each eligible resident at each location; the number of beds at each location which are subject to the agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections.

(b) Providers are required to verify the following minimum requirements in the agreement:

(1) current license or registration, including authorization if managing or monitoring medications;

(2) all staff who have direct contact with recipients meet the staff qualifications;

(3) the provision of housing support;

(4) the provision of supplementary services, if applicable;

(5) reports of adverse events, including recipient death or serious injury; ~~and~~

(6) submission of residency requirements that could result in recipient eviction~~.~~; and

(7) confirmation that the provider will not limit or restrict the number of hours an applicant or recipient chooses to be employed, as specified in subdivision 5.

(c) Agreements may be terminated with or without cause by the commissioner, the agency, or the provider with two calendar months prior notice. The commissioner may immediately terminate an agreement under subdivision 2d.

Sec. 30. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision to read:

Subd. 2h. **Required supplementary services.** Providers of supplementary services shall ensure that recipients have, at a minimum, assistance with services as identified in the recipient's professional statement of need under section 256I.03, subdivision 12. Providers of supplementary services shall maintain case notes with the date and description of services provided to individual recipients.

Sec. 31. Minnesota Statutes 2016, section 256I.04, is amended by adding a subdivision to read:

Subd. 5. **Employment.** A provider is prohibited from limiting or restricting the number of hours an applicant or recipient is employed.

Sec. 32. Minnesota Statutes 2017 Supplement, section 256I.05, subdivision 3, is amended to read:

Subd. 3. **Limits on rates.** When a room and board rate is used to pay for an individual's room and board, the rate payable to the residence must not exceed the rate paid by an individual not receiving a room and board rate ~~under this chapter~~ but who is eligible under section 256I.04, subdivision 1.

Sec. 33. Laws 2014, chapter 312, article 27, section 76, is amended to read:

Sec. 76. **DISABILITY WAIVER REIMBURSEMENT RATE ADJUSTMENTS.**

~~Subdivision 1.~~ **~~Historical rate.~~** The commissioner of human services shall adjust the historical rates calculated in Minnesota Statutes, section 256B.4913, subdivision 4a, paragraph (b), in effect during the banding period under Minnesota Statutes, section

256B.4913, subdivision 4a, paragraph (a), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.

~~Subd. 2. **Residential support services.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 6, paragraphs (b), clause (4), and (c), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 3. **Day programs.** The commissioner of human services shall adjust the rates calculated in Minnesota Statutes, section 256B.4914, subdivision 7, paragraph (a), clauses (15) to (17), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 4. **Unit-based services with programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 8, paragraph (a), clause (14), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

~~Subd. 5. **Unit-based services without programming.** The commissioner of human services shall adjust the rate calculated in Minnesota Statutes, section 256B.4914, subdivision 9, paragraph (a), clause (23), for the reimbursement rate increases effective April 1, 2014, and any rate modification enacted during the 2014 legislative session.~~

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

Sec. 34. Laws 2017, First Special Session chapter 6, article 1, section 52, is amended to read:

Sec. 52. **RANDOM MOMENT TIME STUDY EVALUATION REQUIRED.**

The commissioner of human services shall implement administrative efficiencies and evaluate the random moment time study methodology for reimbursement of costs associated with county duties required under Minnesota Statutes, section 256B.0911. The evaluation must determine whether random moment is efficient and effective in supporting functions of assessment and support planning and the purpose under Minnesota Statutes, section 256B.0911, subdivision 1. The commissioner shall submit a report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by January 15, 2019. The report must include at least one option for a flat-rate payment methodology for long-term care consultation assessment and support planning services, draft legislation to implement the flat-rate options, a fiscal analysis of the flat-rate options, and a policy analysis of the flat-rate options, including the

commissioner's rationale for supporting or opposing the option that is, in the commissioner's opinion, the best of the flat-rate options.

Sec. 35. 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, 2019, 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. 36. **ANALYSIS OF LICENSING ADULT FOSTER CARE.**

The commissioner shall complete an analysis of settings identified by the commissioner, in collaboration with county licensing agencies, as needing a license under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clause (7), to determine if revisions to the definition of residential program for recipients of home and community-based waiver services are needed. The commissioner shall engage stakeholders, including licensed providers of services governed by Minnesota Statutes, chapter 245D, and family members who own and maintain control of the residence in which the service recipients live, in the process of determining if revisions are needed and developing recommendations. The commissioner shall provide a summary of the analysis and stakeholder input along with recommendations, if any, to revise the definition of residential program under Minnesota

Statutes, section 245A.02, subdivision 14, to the chairs and ranking minorities members of the legislative committees with jurisdiction over human services by February 15, 2019.

Sec. 37. **DIRECTION TO COMMISSIONER.**

Between July 1, 2018, and December 31, 2018, the commissioner of human services shall continue to reimburse the Centers for Medicare and Medicaid Services for the disallowed federal share of the rate increases described in Laws 2014, chapter 312, article 27, section 76, subdivisions 2 to 5.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 38. **DIRECTION TO COMMISSIONER; BI AND CADI WAIVER CUSTOMIZED LIVING SERVICES PROVIDER LOCATED IN HENNEPIN COUNTY.**

(a) The commissioner of human services shall allow a housing with services establishment located in Minneapolis that provides customized living and 24-hour customized living services for clients enrolled in the brain injury (BI) or community access for disability inclusion (CADI) waiver and had a capacity to serve 66 clients as of July 1, 2017, to transfer service capacity of up to 66 clients to no more than three new housing with services establishments located in Hennepin County.

(b) Notwithstanding Minnesota Statutes, section 256B.492, the commissioner shall determine whether the new housing with services establishments described under paragraph (a) meet the BI and CADI waiver customized living and 24-hour customized living size limitation exception for clients receiving those services at the new housing with services establishments described under paragraph (a).

Sec. 39. **DIRECTION TO COMMISSIONER.**

(a) The commissioner of human services must ensure that the MnCHOICES 2.0 assessment and support planning tool incorporates a qualitative approach with open-ended questions and a conversational, culturally sensitive approach to interviewing that captures the assessor's professional judgment based on the person's responses.

(b) If the commissioner of human services convenes a working group or consults with stakeholders for the purposes of modifying the assessment and support planning process or tool, the commissioner must include members of the disability community, including representatives of organizations and individuals involved in assessment and support planning.

Sec. 40. **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. 41. **REPEALER.**

Minnesota Statutes 2016, section 256B.0705, is repealed.

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

ARTICLE 4

HEALTH CARE

Section 1. Minnesota Statutes 2017 Supplement, 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 437.121, 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. Paragraph (c) is effective January 1, 2019.

Sec. 2. Minnesota Statutes 2016, 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 July 1, 2018.

Sec. 3. Minnesota Statutes 2016, 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.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 4. Minnesota Statutes 2016, 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. 5. **DIRECTION TO COMMISSIONER.**

By August 1, 2020, 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 commission must include a recommendation, based on the findings in the report, regarding expanding the driver enrollment requirement.

Sec. 6. **REPEALER.**

Minnesota Statutes 2016, section 256B.0625, subdivision 18b, is repealed.

ARTICLE 5

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2018" and "2019" used in this article mean that the addition to or subtraction from appropriations listed under them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively. Base level adjustments mean the addition or subtraction from the base level adjustments in Laws 2017, First Special Session chapter 6, article 18. "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium" is fiscal years 2018 and 2019. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2018, are effective the day following final enactment unless a different effective date is specified.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2018	**2019**

Sec. 2. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$ 26,941,000**

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Central Office; Operations** -0- 5,289,000

(a) **Transfers.** By June 30, 2019, the commissioner of management and budget shall transfer $4,149,000 from the general fund to the health care access fund. By June 30, 2020, the commissioner of management and budget shall transfer $4,149,000 from the health care access fund to the general fund.

(b) **Base Level Adjustment.** The general fund base is increased by $6,558,000 in fiscal year 2020 and increased by $6,581,000 in fiscal year 2021.

Subd. 3. **Central Office; Children and Families** -0- 633,000

(a) **Child Welfare Training.** $1,933,000 in fiscal year 2019 is for initial costs for the child welfare training in Minnesota Statutes, section 260C.81. No money from this appropriation may be used for indirect costs by an entity under contract to implement Minnesota Statutes, section 260C.81.

(b) **Base Level Adjustment.** The general fund base is increased by $650,000 in fiscal year 2020 and increased by $650,000 in fiscal year 2021.

Subd. 4. **Central Office; Health Care** -0- 1,024,000

Base Level Adjustment. The general fund base is increased by $1,507,000 in fiscal year 2020 and increased by $1,513,000 in fiscal year 2021.

Subd. 5. **Central Office; Continuing Care for Older Adults** -0- 418,000

Base Level Adjustment. The general fund base is increased by $425,000 in fiscal year 2020 and increased by $425,000 in fiscal year 2021.

Subd. 6. **Central Office; Community Supports**	-0-	4,280,000

Base Level Adjustment. The general fund base is increased by $4,280,000 in fiscal year 2020 and increased by $4,260,000 in fiscal year 2021.

Subd. 7. **Forecasted Programs; Medical Assistance**	-0-	25,101,000
Subd. 8. **Forecasted Programs; Alternative Care**	-0-	(28,000)
Subd. 9. **Forecasted Programs; Chemical Dependency Treatment Fund**	-0-	(14,243,000)
Subd. 10. **Grant Programs; Child Mental Health Grants**	-0-	4,467,000

(a) **School-Linked Mental Health Services by Telemedicine.** $4,467,000 in fiscal year 2019 is to sustain and expand grants under Minnesota Statutes, section 245.4889, subdivision 1, paragraph (b), clause (8), including the delivery of school-linked mental health services by telemedicine. This appropriation is available until June 30, 2021.

(b) **Base Level Adjustment.** The general fund base is increased by $9,467,000 in fiscal year 2020.

Sec. 3. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2019, unless a different expiration date is specified.

Sec. 4. **EFFECTIVE DATE.**

This article is effective July 1, 2018, unless a different effective date is specified.

APPENDIX
Article locations in SF3937-1

256B.0625 COVERED SERVICES.

Subd. 18b. **Broker dispatching prohibition.** Except for establishing level of service process, the commissioner shall not use a broker or coordinator for any purpose related to nonemergency medical transportation services under subdivision 18.

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.