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01/10/2019	45	Introduction and first reading Referred to Family Care and Aging
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01/17/2019	92	Comm report: To pass and re-referred to Family Care and Aging
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01/22/2019	141	Author added Nelson
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03/14/2019	936a	Comm report: To pass as amended and re-refer to Judiciary and Public Safety Finance and Policy
04/01/2019	1517a	Comm report: To pass as amended and re-refer to Human Services Reform Finance and Policy Joint rule 2.03, referred to Rules and Administration

1.1 A bill for an act

1.2 relating to human services; clarifying counted income for eligibility determinations
1.3 for public assistance and child care programs; creating surety bond requirements
1.4 for child care program providers; modifying surety bond requirements for durable
1.5 medical supply providers; modifying documentation requirements for child care
1.6 program providers, personal care assistance providers, mental health providers,
1.7 and home and community-based services providers; modifying commissioner of
1.8 human services' authority to exclude providers from programs administered by
1.9 the commissioner; modifying provider enrollment requirements for medical
1.10 assistance; establishing a visit verification system for home and community-based
1.11 services; requiring a report; appropriating money; amending Minnesota Statutes
1.12 2018, sections 119B.09, subdivision 4; 119B.125, subdivision 6, by adding a
1.13 subdivision; 144A.479, by adding a subdivision; 245.095; 256.476, subdivision
1.14 10; 256.98, subdivisions 1, 8; 256B.02, subdivision 7, by adding a subdivision;
1.15 256B.04, subdivision 21; 256B.056, subdivisions 3, 4; 256B.0625, subdivisions
1.16 17, 18h, 43, by adding subdivisions; 256B.064, subdivision 1b; 256B.0651,
1.17 subdivision 17; 256B.0659, subdivisions 3, 12, 13, 14, 19, 21, 24; 256B.0949,
1.18 subdivision 15; 256B.4912, by adding subdivisions; 256B.5014; 256B.85,
1.19 subdivision 10; 256J.08, subdivision 47; 256J.21, subdivision 2; 256L.01,
1.20 subdivision 5; 256P.04, subdivision 4; 256P.06, subdivision 3; Laws 2017, First
1.21 Special Session chapter 6, article 3, section 49; proposing coding for new law in
1.22 Minnesota Statutes, chapter 256B; repealing Minnesota Statutes 2018, section
1.23 256B.0705.

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

1.25 Section 1. Minnesota Statutes 2018, section 119B.09, subdivision 4, is amended to read:

1.26 Subd. 4. **Eligibility; annual income; calculation.** (a) Annual income of the applicant
1.27 family is the current monthly income of the family multiplied by 12 or the income for the
1.28 12-month period immediately preceding the date of application, or income calculated by
1.29 the method which provides the most accurate assessment of income available to the family.

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

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

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

Subd. 1c. **Surety bond coverage required.** The provider is required to provide proof of surety bond coverage of $....... at authorization and reauthorization if the provider's child care assistance program payments in the previous calendar year total $100,000 or more. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond.

Sec. 3. Minnesota Statutes 2018, section 119B.125, subdivision 6, is amended to read:

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

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

(c) A county or the commissioner may deny or revoke a provider's authorization ~~as a child care provider to any applicant, rescind authorization of any provider,~~ to receive child care assistance payments under section 119B.13, subdivision 6, paragraph (d), pursue a

fraud disqualification under section 256.98, take an action against the provider under chapter 245E, or establish an attendance record overpayment ~~claim in the system~~ under paragraph (d) against a current or former provider, when the county or the commissioner knows or has reason to believe that the provider has not complied with the record-keeping requirement in this subdivision. ~~A provider's failure to produce attendance records as requested on more than one occasion constitutes grounds for disqualification as a provider.~~

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

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

Sec. 4. Minnesota Statutes 2018, section 144A.479, is amended by adding a subdivision to read:

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

Sec. 5. Minnesota Statutes 2018, section 245.095, is amended to read:

245.095 LIMITS ON RECEIVING PUBLIC FUNDS.

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

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

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

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

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

4.3 (b) "Excluded" means disenrolled, ~~subject to license revocation or suspension,~~
4.4 ~~disqualified, or subject to vendor debarment~~ disqualified, has a license that has been revoked
4.5 or suspended under chapter 245A, has been debarred or suspended under Minnesota Rules,
4.6 part 1230.1150, or terminated from participation in medical assistance under section
4.7 256B.064.

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

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

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

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

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

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

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

4.21 (4) arrange and pay for supports; and

4.22 (5) inform the local agency of areas where they have experienced difficulty securing or
4.23 maintaining supports.

4.24 Sec. 7. Minnesota Statutes 2018, section 256.98, subdivision 1, is amended to read:

4.25 Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the
4.26 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
4.27 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
4.28 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
4.29 256L, child care assistance programs, and emergency assistance programs under section
4.30 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
4.31 (1) to (5):

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

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

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

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

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

Subd. 8. **Disqualification from program.** (a) Any person found to be guilty of wrongfully obtaining assistance by a federal or state court or by an administrative hearing determination, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions, in the Minnesota family investment program and any affiliated program to include the diversionary work program and the work participation cash benefit program, the food stamp or food support program, the general assistance program, housing support under chapter 256I, or the Minnesota supplemental aid program shall be disqualified from that program. The disqualification based on a finding or action by a federal or state court is a permanent disqualification. The disqualification based on an administrative hearing, or waiver thereof, through a disqualification consent agreement, or as part of any approved diversion plan under section 401.065, or any court-ordered stay which carries with it any probationary or other conditions must be for a period of two years for the first offense and a permanent disqualification for the second offense. In addition, any person disqualified from the Minnesota family investment program shall also be disqualified from the food stamp or food support program. The needs of that

individual shall not be taken into consideration in determining the grant level for that assistance unit~~:~~.

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

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

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

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

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

(c) A provider caring for children receiving assistance through child care assistance programs under chapter 119B is disqualified from receiving payment for child care services from the child care assistance program under chapter 119B when the provider is found to

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

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

Sec. 9. Minnesota Statutes 2018, section 256B.02, subdivision 7, is amended to read:

Subd. 7. **Vendor of medical care.** (a) "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, ambulatory surgical center services, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in

8.1 section 145A.02, subdivision 18; health care services provided at the residence of the patient
8.2 if the services are performed by a public health nurse and the nurse indicates in a statement
8.3 submitted under oath that the services were actually provided; and such other medical
8.4 services or supplies provided or prescribed by persons authorized by state law to give such
8.5 services and supplies, including services under section 256B.4912. For purposes of this
8.6 chapter, the term includes a person or entity that furnishes a good or service eligible for
8.7 medical assistance or federally approved waiver plan payments under this chapter. The term
8.8 includes, but is not limited to, directors and officers of corporations or members of
8.9 partnerships who, either individually or jointly with another or others, have the legal control,
8.10 supervision, or responsibility of submitting claims for reimbursement to the medical
8.11 assistance program. The term only includes directors and officers of corporations who
8.12 personally receive a portion of the distributed assets upon liquidation or dissolution, and
8.13 their liability is limited to the portion of the claim that bears the same proportion to the total
8.14 claim as their share of the distributed assets bears to the total distributed assets.

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

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

8.29 Sec. 10. Minnesota Statutes 2018, section 256B.02, is amended by adding a subdivision
8.30 to read:

8.31 Subd. 20. **Income.** Income is calculated using the adjusted gross income methodology
8.32 under the Affordable Care Act. Income includes funds in personal or business accounts
8.33 used to pay personal expenses including rent, mortgage, automobile-related expenses,
8.34 utilities, food, and other personal expenses not directly related to the business, unless the

9.1 funds are directly attributable to an exception to the income requirement specifically
9.2 identified by the applicant.

9.3 Sec. 11. Minnesota Statutes 2018, section 256B.04, subdivision 21, is amended to read:

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

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

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

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

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

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

9.24 (1) autism early intensive behavioral intervention benefits according to section
9.25 256B.0949;

9.26 (2) consumer directed community supports; and

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

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

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

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

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

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

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

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

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

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

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

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

~~(c)~~ (h) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or

11.1 referrals for other items or services written or ordered by such provider, when the
11.2 commissioner has identified a pattern of a lack of documentation. A pattern means a failure
11.3 to maintain documentation or provide access to documentation on more than one occasion.
11.4 Nothing in this paragraph limits the authority of the commissioner to sanction a provider
11.5 under the provisions of section 256B.064.

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

11.9 ~~(e)~~ (j) As a condition of enrollment in medical assistance, the commissioner shall require
11.10 that a provider designated "moderate" or "high-risk" by the Centers for Medicare and
11.11 Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid
11.12 Services, its agents, or its designated contractors and the state agency, its agents, or its
11.13 designated contractors to conduct unannounced on-site inspections of any provider location.
11.14 The commissioner shall publish in the Minnesota Health Care Program Provider Manual a
11.15 list of provider types designated "limited," "moderate," or "high-risk," based on the criteria
11.16 and standards used to designate Medicare providers in Code of Federal Regulations, title
11.17 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.
11.18 The commissioner's designations are not subject to administrative appeal.

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

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

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must ~~allow for recovery of costs and fees in pursuing a claim on the bond~~ be in a form approved by the commissioner, renewed annually, and allow for recovery of the entire value of the bond for up to five years from the date of submission of a claim for medical assistance payment if the enrolled provider violates this chapter or Minnesota Rules, chapter 9505, regardless of the actual loss.

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

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

Sec. 12. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

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

13.1 eligibility redetermination. The value of assets that are not considered in determining
13.2 eligibility for medical assistance is the value of those assets excluded under the Supplemental
13.3 Security Income program for aged, blind, and disabled persons, with the following
13.4 exceptions:

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

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

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

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

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

13.21 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
13.22 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before
13.23 the person's 65th birthday, the assets owned by the person and the person's spouse must be
13.24 disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when
13.25 determining eligibility for medical assistance under section 256B.055, subdivision 7. The
13.26 income of a spouse of a person enrolled in medical assistance under section 256B.057,
13.27 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
13.28 must be disregarded when determining eligibility for medical assistance under section
13.29 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
13.30 in section 256B.059; and

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

14.1 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
14.2 15.

14.3 Sec. 13. Minnesota Statutes 2018, section 256B.056, subdivision 4, is amended to read:

14.4 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
14.5 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
14.6 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
14.7 Supplemental Security Income may have an income up to the Supplemental Security Income
14.8 standard in effect on that date.

14.9 (b) Effective January 1, 2014, to be eligible for medical assistance, under section
14.10 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
14.11 percent of the federal poverty guidelines for the household size.

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

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

14.18 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
14.19 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
14.20 household size or an equivalent standard when converted using modified adjusted gross
14.21 income methodology as required under the Affordable Care Act. Children who are enrolled
14.22 in medical assistance as of December 31, 2013, and are determined ineligible for medical
14.23 assistance because of the elimination of income disregards under modified adjusted gross
14.24 income methodology as defined in subdivision 1a remain eligible for medical assistance
14.25 under the Children's Health Insurance Program Reauthorization Act of 2009, Public Law
14.26 111-3, until the date of their next regularly scheduled eligibility redetermination as required
14.27 in subdivision 7a.

14.28 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
14.29 who are not residents of long-term care facilities, the commissioner shall: (1) disregard
14.30 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.
14.31 For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans
14.32 Administration unusual medical expense payments are considered income to the recipient.;
14.33 and (2) include all assets available to the applicant that are considered income according to

15.1 the Internal Revenue Service. Income includes all deposits into accounts owned or controlled
15.2 by the applicant, including amounts spent on personal expenses, including rent, mortgage,
15.3 automobile-related expenses, utilities, and food and amounts received as salary or draws
15.4 from business accounts and not otherwise excluded by federal or state laws. Income does
15.5 not include a deposit specifically identified by the applicant as a loan or gift, for which the
15.6 applicant provides the source, date, amount, and repayment terms.

15.7 Sec. 14. Minnesota Statutes 2018, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

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

15.23 (c) Medical assistance covers nonemergency medical transportation provided by
15.24 nonemergency medical transportation providers enrolled in the Minnesota health care
15.25 programs. All nonemergency medical transportation providers must comply with the
15.26 operating standards for special transportation service as defined in sections 174.29 to 174.30
15.27 and Minnesota Rules, chapter 8840~~, and in consultation with the Minnesota Department of~~
15.28 ~~Transportation~~. All drivers providing nonemergency medical transportation must be
15.29 individually enrolled with the commissioner if the driver is a subcontractor for or employed
15.30 by a provider that both has a base of operation located within a metropolitan county listed
15.31 in section 473.121, subdivision 4, and is listed in paragraph (b), clause (1) or (3). All
15.32 nonemergency medical transportation providers shall bill for nonemergency medical
15.33 transportation services in accordance with Minnesota health care programs criteria. Publicly

16.1 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
16.2 requirements outlined in this paragraph.

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

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

16.6 (2) the provider has initiated background studies on the individuals specified in section
16.7 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

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

16.27 (g) The commissioner may use an order by the recipient's attending physician or a medical
16.28 or mental health professional to certify that the recipient requires nonemergency medical
16.29 transportation services. Nonemergency medical transportation providers shall perform
16.30 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
16.31 includes passenger pickup at and return to the individual's residence or place of business,

17.1 assistance with admittance of the individual to the medical facility, and assistance in
17.2 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

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

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

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

17.19 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

18.14 (k) The commissioner shall:

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

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

18.18 (3) investigate all complaints and appeals.

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

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

18.28 (1) $0.22 per mile for client reimbursement;

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

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

19.4 (4) $13 for the base rate and $1.30 per mile for assisted transport;

19.5 (5) $18 for the base rate and $1.55 per mile for lift-equipped/ramp transport;

19.6 (6) $75 for the base rate and $2.40 per mile for protected transport; and

19.7 (7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for
19.8 an additional attendant if deemed medically necessary.

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

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

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

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

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

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

19.26 **EFFECTIVE DATE.** The amendments to paragraph (c) are effective January 1, 2020.

19.27 Sec. 15. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision
19.28 to read:

19.29 Subd. 17d. **Transportation services oversight.** The commissioner shall contract with
19.30 a vendor or dedicate staff for oversight of providers of nonemergency medical transportation

services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

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

Sec. 16. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

(2) subdivision 18; and

(3) subdivision 18a.

~~(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and~~

~~Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.~~

Sec. 19. Minnesota Statutes 2018, section 256B.0625, subdivision 43, is amended to read:

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

(b) Mental health provider travel time under this subdivision covers the time the provider is in transit to deliver a mental health service to a recipient at a location that is not the provider's usual place of business or to the next location for delivery of a covered mental health service, and the time a provider is in transit returning from the location of the last recipient who received services on that day to the provider's usual place of business. A provider must travel the most direct route available. Mental health provider travel time does not include time for scheduled or unscheduled stops, meal breaks, or vehicle maintenance or repair, including refueling or vehicle emergencies. Recipient transportation is not covered under this subdivision.

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

(d) If the first occurrence of mental health provider travel time in a day begins at a location other than the provider's usual place of business, the provider shall bill for the lesser of the travel time between the location and the recipient and the travel time between the provider's usual place of business and the recipient. This provision does not apply to mental health crisis services provided under section 256B.0624 outside of normal business hours if on-call staff are dispatched directly from a location other than the provider's usual place of business.

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

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

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

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

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

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

22.11 (4) each entry in the record must document:

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

22.13 (ii) the date the travel occurred;

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

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

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

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

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

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

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

23.1 Sec. 20. Minnesota Statutes 2018, section 256B.064, subdivision 1b, is amended to read:

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

23.13 Sec. 21. **[256B.0646] CORRECTIVE ACTIONS FOR PEOPLE USING PERSONAL**
23.14 **CARE ASSISTANCE SERVICES; MINNESOTA RESTRICTED RECIPIENT**
23.15 **PROGRAM.**

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

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

23.22 (2) obtain a new assessment as described in section 256B.0911, including consultation
23.23 with a registered or public health nurse on the long-term care consultation team under section
23.24 256B.0911, subdivision 3, paragraph (b), clause (2); and

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

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

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

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

24.1 Sec. 22. Minnesota Statutes 2018, section 256B.0651, subdivision 17, is amended to read:

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

24.12 (b) In the event of a payment withhold from a home care provider, a suspension of
24.13 participation, or a termination of participation of a home care provider under section
24.14 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care
24.15 and the lead agencies for all recipients with active service agreements with the provider. At
24.16 the commissioner's request, the lead agencies must contact recipients to ensure that the
24.17 recipients are continuing to receive needed care, and that the recipients have been given
24.18 free choice of provider if they transfer to another home care provider. In addition, the
24.19 commissioner or the commissioner's delegate may directly notify recipients who receive
24.20 care from the provider that payments have been <u>or will be</u> withheld or that the provider's
24.21 participation in medical assistance has been <u>or will be</u> suspended or terminated, if the
24.22 commissioner determines that notification is necessary to protect the welfare of the recipients.
24.23 For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care
24.24 organizations.

24.25 Sec. 23. Minnesota Statutes 2018, section 256B.0659, subdivision 3, is amended to read:

24.26 Subd. 3. **~~Noncovered~~ Personal care assistance services <u>not covered</u>.** (a) Personal care
24.27 assistance services are not eligible for medical assistance payment under this section when
24.28 provided:

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

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

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

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

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

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

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

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

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

25.14 (1) sterile procedures;

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

25.16 (3) home maintenance or chore services;

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

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

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

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

25.25 Sec. 24. Minnesota Statutes 2018, section 256B.0659, subdivision 12, is amended to read:

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

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

Sec. 25. Minnesota Statutes 2018, section 256B.0659, subdivision 13, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2018, section 256B.0659, subdivision 14, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29.28 (2) agency administrative activities;

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

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

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

30.6 Sec. 27. Minnesota Statutes 2018, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31.23 Sec. 28. Minnesota Statutes 2018, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

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

32.9 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34.29 Sec. 29. Minnesota Statutes 2018, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2018, section 256B.0949, subdivision 15, is amended to read:

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

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

36.6 (2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised
36.7 clinical experience or training in examining or treating people with ASD or a related condition
36.8 or equivalent documented coursework at the graduate level by an accredited university in
36.9 the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and
36.10 typical child development.

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

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

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

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

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

36.25 (iii) a board-certified behavior analyst; or

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

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

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

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

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

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

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

37.12 (2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38.17 Sec. 31. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
38.18 to read:

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

38.25 (1) number of direct-care staff;

38.26 (2) wages of direct-care staff;

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

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

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

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

38.31 (7) direct-care staff retention rates;

39.1 (8) direct-care staff job vacancies;

39.2 (9) amount of travel time paid;

39.3 (10) program vacancy rates; and

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

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

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

39.12 (d) This subdivision also applies to a provider of personal care assistance services under
39.13 section 256B.0625, subdivision 19a; community first services and supports under section
39.14 256B.85; nursing services and home health services under section 256B.0625, subdivision
39.15 6a; home care nursing services under section 256B.0625, subdivision 7; or day training and
39.16 habilitation services for residents of intermediate care facilities for persons with
39.17 developmental disabilities under section 256B.501.

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

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

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

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

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

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

40.6 Sec. 32. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
40.7 to read:

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

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

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

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

40.16 A service that does not meet the criteria in this subdivision may be recovered by the
40.17 department according to section 256B.064 and Minnesota Rules, parts 9505.2160 to
40.18 9505.2245.

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

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

40.25 Sec. 33. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
40.26 to read:

40.27 Subd. 12. **Home and community-based service documentation requirements.** (a)
40.28 Documentation may be collected and maintained electronically or in paper form by providers,
40.29 but must be made available and produced upon the request of the commissioner.
40.30 Documentation of delivered services that comply with the electronic visit verification

41.1 requirements under Laws 2017, First Special Session chapter 6, article 3, section 49, satisfy
41.2 the requirements of this subdivision.

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

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

41.7 (1) the date the documentation occurred;

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

41.9 (3) the start and stop times with a.m. and p.m. designations, except for case management
41.10 services as defined under sections 256B.0913, subdivision 7, 256B.0915, subdivision 1a,
41.11 256B.092, subdivision 1a, and 256B.49, subdivision 13;

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

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

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

41.19 (1) the date the documentation occurred;

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

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

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

41.25 Sec. 34. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
41.26 to read:

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

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

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

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

42.5 (1) odometer and other records as provided in section 256B.0625, subdivision 17b,
42.6 paragraph (b), clause (3), sufficient to distinguish an individual trip with a specific vehicle
42.7 and driver for a waiver transportation service that is billed directly by the mile, except if
42.8 the provider is a common carrier as defined by Minnesota Rules, part 9505.0315, subpart
42.9 1, item B, or a publicly operated transit system; and

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

42.13 Sec. 35. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
42.14 to read:

42.15 Subd. 14. **Equipment and supply documentation requirements.** (a) An equipment
42.16 and supply services provider must meet the documentation requirements under section
42.17 256B.4912, subdivision 12, and must, for each documentation of the provision of a service,
42.18 include:

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

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

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

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

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

43.1 Sec. 36. Minnesota Statutes 2018, section 256B.4912, is amended by adding a subdivision
43.2 to read:

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

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

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

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

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

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

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

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

43.25 Sec. 37. Minnesota Statutes 2018, section 256B.5014, is amended to read:

43.26 **256B.5014 ~~FINANCIAL~~ REPORTING REQUIREMENTS.**

43.27 Subdivision 1. **Financial reporting.** All facilities shall maintain financial records and
43.28 shall provide annual income and expense reports to the commissioner of human services
43.29 on a form prescribed by the commissioner no later than April 30 of each year in order to
43.30 receive medical assistance payments. The reports for the reporting year ending December
43.31 31 must include:

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

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

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

44.8 (4) total annual resident days.

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

44.11 Sec. 38. Minnesota Statutes 2018, section 256B.85, subdivision 10, is amended to read:

44.12 Subd. 10. **Agency-provider and FMS provider qualifications and duties.** (a)
44.13 Agency-providers identified in subdivision 11 and FMS providers identified in subdivision
44.14 13a shall:

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

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

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

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

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

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

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

44.29 (8) have never had a lead agency contract or provider agreement discontinued due to
44.30 fraud, or have never had an owner, board member, or manager fail a state or FBI-based

45.1 criminal background check while enrolled or seeking enrollment as a Minnesota health care
45.2 programs provider; and

45.3 (9) have an office located in Minnesota.

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

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

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

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

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

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

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

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

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

45.19 Sec. 39. Minnesota Statutes 2018, section 256J.08, subdivision 47, is amended to read:

45.20 Subd. 47. **Income.** "Income" means cash or in-kind benefit, whether earned or unearned,
45.21 received by or available to an applicant or participant that is not property under section
45.22 256P.02. An applicant must document that the property is not available to the applicant.

45.23 Sec. 40. Minnesota Statutes 2018, section 256J.21, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

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

(iv) federal or state tax rebates;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47.25 (25) rent rebates;

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

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

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

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

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

48.4 (31) reverse mortgages;

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

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

48.9 (34) benefits from the National School Lunch Act, United States Code, title 42, chapter
48.10 13, sections 1751 to 1769e;

48.11 (35) relocation assistance for displaced persons under the Uniform Relocation Assistance
48.12 and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter
48.13 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12,
48.14 chapter 13, sections 1701 to 1750jj;

48.15 (36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part
48.16 2, sections 2271 to 2322;

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

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

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

48.24 (40) security and utility deposit refunds;

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

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

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

49.6 (44) payments made to children eligible for relative custody assistance under section
49.7 257.85;

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

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

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

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

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

49.17 Sec. 41. Minnesota Statutes 2018, section 256L.01, subdivision 5, is amended to read:

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

49.24 Sec. 42. Minnesota Statutes 2018, section 256P.04, subdivision 4, is amended to read:

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

49.26 (1) identity of adults;

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

49.28 (3) immigration status;

49.29 (4) income;

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

50.1 (6) vehicles;

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

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

50.7 (9) residence;

50.8 (10) Social Security number; and

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

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

50.13 (13) direct or indirect gifts of money.

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

50.21 Sec. 43. Minnesota Statutes 2018, section 256P.06, subdivision 3, is amended to read:

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

50.24 (1) earned income:

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

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

51.1 (2) unearned income, which includes:

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

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

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

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

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

51.8 (vi) cash prizes and winnings;

51.9 (vii) unemployment insurance income;

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

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

51.14 (x) retirement benefits;

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

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

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

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

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

51.23 (xvi) the amount of child support received that exceeds $100 for assistance units with
51.24 one child and $200 for assistance units with two or more children for programs under chapter
51.25 256J; and

51.26 (xvii) spousal support.

Sec. 44. 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

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

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

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

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

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

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

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

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

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

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

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

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

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

54.4 (c) Providers must implement the electronic visit verification systems required under
54.5 this section by January 1, 2020, for personal care services and by January 1, 2023, for home
54.6 health services in accordance with the 21st Century Cures Act, Public Law 114-255, and
54.7 the Centers for Medicare and Medicaid Services guidelines. For the purposes of this
54.8 paragraph, "personal care services" and "home health services" have the meanings given
54.9 in United States Code, title 42, section 1396b(l)(5).

54.10 (d) Notwithstanding paragraph (c), the commissioner of human services shall take no
54.11 enforcement actions, including reducing reimbursement rates, against a provider for failing
54.12 to comply with this section until six months after the commissioner has fulfilled the
54.13 commissioner's obligations under subdivision 3, paragraphs (b) and (d), including making
54.14 an electronic visit verification data aggregator available to providers of services. If, during
54.15 this six-month period, federal financial participation in reimbursement for provided services
54.16 is denied because a provider is not in compliance with this section, the commissioner shall
54.17 use state-only funds to pay the full rate for provided services.

54.18 ~~Subd. 4.~~ **~~Legislative report.~~** ~~(a) The commissioner shall submit a report by January 15,~~
54.19 ~~2018, to the chairs and ranking minority members of the legislative committees with~~
54.20 ~~jurisdiction over human services with recommendations, based on the requirements of~~
54.21 ~~subdivision 3, to establish electronic service delivery documentation system requirements~~
54.22 ~~and standards. The report shall identify:~~

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

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

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

54.31 Sec. 45. **DIRECTIONS TO THE COMMISSIONER.**

54.32 By August 1, 2021, the commissioner of human services shall issue a report to the chairs
54.33 and ranking minority members of the house of representatives and senate committees with

55.1 jurisdiction over health and human services. The commissioner must include in the report
55.2 the commissioner's findings regarding the impact of driver enrollment under Minnesota
55.3 Statutes, section 256B.0625, subdivision 17, paragraph (c), on the program integrity of the
55.4 nonemergency medical transportation program. The commissioner must include a
55.5 recommendation, based on the findings in the report, regarding expanding the driver
55.6 enrollment requirement.

55.7 Sec. 46. **UNIVERSAL IDENTIFICATION NUMBER FOR CHILDREN IN EARLY**
55.8 **CHILDHOOD PROGRAMS.**

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

55.14 Sec. 47. **APPROPRIATION; FRAUD PREVENTION INVESTIGATIONS.**

55.15 $....... is appropriated in fiscal year 2020 and $....... is appropriated in fiscal year 2021
55.16 from the general fund to the commissioner of human services for the fraud prevention
55.17 investigation project described in Minnesota Statutes, section 256.983.

55.18 Sec. 48. **REVISOR'S INSTRUCTION.**

55.19 The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article
55.20 3, section 49, as amended in this act, in Minnesota Statutes, chapter 256B.

55.21 Sec. 49. **REPEALER.**

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

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

256B.0705 PERSONAL CARE ASSISTANCE SERVICES; MANDATED SERVICE VERIFICATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Personal care assistance services" or "PCA services" means services provided according to section 256B.0659.

(c) "Personal care assistant" or "PCA" has the meaning given in section 256B.0659, subdivision 1.

(d) "Service verification" means a random, unscheduled telephone call made for the purpose of verifying that the individual personal care assistant is present at the location where personal care assistance services are being provided and is providing services as scheduled.

Subd. 2. **Verification schedule.** An agency that submits claims for reimbursement for PCA services under this chapter must develop and implement administrative policies and procedures by which the agency verifies the services provided by a PCA. For each service recipient, the agency must conduct at least one service verification every 90 days. If more than one PCA provides services to a single service recipient, the agency must conduct a service verification for each PCA providing services before conducting a service verification for a PCA whose services were previously verified by the agency. Service verification must occur on an ongoing basis while the agency provides PCA services to the recipient. During service verification, the agency must speak with both the PCA and the service recipient or recipient's authorized representative. Only qualified professional service verifications are eligible for reimbursement. An agency may substitute a visit by a qualified professional that is eligible for reimbursement under section 256B.0659, subdivision 14 or 19.

Subd. 3. **Documentation of verification.** An agency must fully document service verifications in a legible manner and must maintain the documentation on site for at least five years from the date of documentation. For each service verification, documentation must include:

(1) the names and signatures of the service recipient or recipient's authorized representative, the PCA and any other agency staff present with the PCA during the service verification, and the staff person conducting the service verification; and

(2) the start and end time, day, month, and year of the service verification, and the corresponding PCA time sheet.

Subd. 4. **Variance.** The Office of Inspector General at the Department of Human Services may grant a variance to the service verification requirements in this section if an agency uses an electronic monitoring system or other methods that verify a PCA is present at the location where services are provided and is providing services according to the prescribed schedule. A decision to grant or deny a variance request is final and not subject to appeal under chapter 14.