

SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 1324

(SENATE AUTHORS: NELSON)		
DATE	D-PG	OFFICIAL STATUS
02/22/2021	492	Introduction and first reading Referred to Human Services Reform Finance and Policy
03/08/2021	712a	Comm report: To pass as amended and re-refer to Health and Human Services Finance and Policy
03/18/2021	1060a	Comm report: To pass as amended and re-refer to Human Services Reform Finance and Policy See HF2128, Art. 7, Sec. 1-4 See First Special Session 2021, HF33, Art. 6, Sec. 17-19, 24

1.1

A bill for an act

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relating to human services; establishing certain temporary modifications to human

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services programs in response to the COVID-19 pandemic as permanent changes;

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amending Minnesota Statutes 2020, sections 256B.0911, subdivisions 1a, 3a, 3f,

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4d; 256B.49, subdivision 14; 256I.05, subdivision 1c; 256J.08, subdivision 21;

1.6

256J.09, subdivision 3; 256J.45, subdivision 1; 256J.95, subdivision 5; 256S.05,

1.7

subdivision 2.

1.8

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

1.9

Section 1. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to

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read:

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

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

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services" means:

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(1) intake for and access to assistance in identifying services needed to maintain an

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individual in the most inclusive environment;

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(2) providing recommendations for and referrals to cost-effective community services

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that are available to the individual;

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

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

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(5) ~~face-to-face~~ long-term care consultation assessments conducted according to

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subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care

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facility for persons with developmental disabilities (ICF/DDs), regional treatment centers,

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or the person's current or planned residence;

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on a long-term care consultation assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

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

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

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

(10) providing information about independent living to ensure that an informed choice about independent living can be made; and

(11) providing information about self-directed services and supports, including self-directed funding options, to ensure that an informed choice about self-directed options can be made.

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

(1) service eligibility determination for the following state plan services:

(i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

(ii) consumer support grants under section 256.476; or

(iii) community first services and supports under section 256B.85;

(2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024, gaining access to:

(i) relocation targeted case management services available under section 256B.0621, subdivision 2, clause (4);

(ii) case management services targeted to vulnerable adults or developmental disabilities under section 256B.0924; and

(iii) case management services targeted to people with developmental disabilities under Minnesota Rules, part 9525.0016;

(3) determination of eligibility for semi-independent living services under section 252.275; and

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

(c) "Long-term care options counseling" means the services provided by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

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

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

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives, the settings in which the person receives the services, and the setting in which the person lives.

(g) "Informed choice" means a voluntary choice of services, settings, living arrangement, and work by a person from all available service and setting options based on accurate and complete information concerning all available service and setting options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person in a way the person can understand to empower the person to make fully informed choices.

(h) "Available service and setting options" or "available options," with respect to the home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49, means all services and settings defined under the waiver plan for which a waiver applicant or waiver participant is eligible.

4.1 (i) "Independent living" means living in a setting that is not controlled by a provider.

4.2 Sec. 2. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

4.3 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
4.4 planning, or other assistance intended to support community-based living, including persons
4.5 who need assessment in order to determine waiver or alternative care program eligibility,
4.6 must be visited by a long-term care consultation team within 20 calendar days after the date
4.7 on which an assessment was requested or recommended. Upon statewide implementation
4.8 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
4.9 requesting personal care assistance services. The commissioner shall provide at least a
4.10 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~
4.11 Assessments must be conducted according to paragraphs (b) to ~~(i)~~ (q).

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

4.15 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
4.16 be used to complete a comprehensive, conversation-based, person-centered assessment.
4.17 The assessment must include the health, psychological, functional, environmental, and
4.18 social needs of the individual necessary to develop a person-centered community support
4.19 plan that meets the individual's needs and preferences.

4.20 (d) Except as provided in paragraph (q), the assessment must be conducted by a certified
4.21 assessor in a face-to-face conversational interview with the person being assessed. The
4.22 person's legal representative must provide input during the assessment process and may do
4.23 so remotely if requested. At the request of the person, other individuals may participate in
4.24 the assessment to provide information on the needs, strengths, and preferences of the person
4.25 necessary to develop a community support plan that ensures the person's health and safety.
4.26 Except for legal representatives or family members invited by the person, persons
4.27 participating in the assessment may not be a provider of service or have any financial interest
4.28 in the provision of services. For persons who are to be assessed for elderly waiver customized
4.29 living or adult day services under chapter 256S, with the permission of the person being
4.30 assessed or the person's designated or legal representative, the client's current or proposed
4.31 provider of services may submit a copy of the provider's nursing assessment or written
4.32 report outlining its recommendations regarding the client's care needs. The person conducting
4.33 the assessment must notify the provider of the date by which this information is to be
4.34 submitted. This information shall be provided to the person conducting the assessment prior

to the assessment. For a person who is to be assessed for waiver services under section 256B.092 or 256B.49, with the permission of the person being assessed or the person's designated legal representative, the person's current provider of services may submit a written report outlining recommendations regarding the person's care needs the person completed in consultation with someone who is known to the person and has interaction with the person on a regular basis. The provider must submit the report at least 60 days before the end of the person's current service agreement. The certified assessor must consider the content of the submitted report prior to finalizing the person's assessment or reassessment.

(e) The certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and the coordinated service and support plan no more than 60 calendar days from the assessment visit. The person or the person's legal representative must be provided with a written community support plan within the timelines established by the commissioner, regardless of whether the person is eligible for Minnesota health care programs.

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

(g) The written community support plan must include:

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

(2) the individual's options and choices to meet identified needs, including:

(i) all available options for case management services and providers;

(ii) all available options for employment services, settings, and providers;

(iii) all available options for living arrangements;

(iv) all available options for self-directed services and supports, including self-directed budget options; and

(v) service provided in a non-disability-specific setting;

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

(i) The person has the right to make the final decision:

(1) between institutional placement and community placement after the recommendations have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

(2) between community placement in a setting controlled by a provider and living independently in a setting not controlled by a provider;

(3) between day services and employment services; and

(4) regarding available options for self-directed services and supports, including self-directed funding options.

(j) The lead agency must give the person receiving long-term care consultation services or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

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

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

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

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

(5) information about Minnesota health care programs;

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

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

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

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

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the individual.

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

(l) The effective eligibility start date for programs in paragraph (k) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (k) cannot be prior to the date the most recent updated assessment is completed.

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

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver residential supports and services currently residing in a community residential setting, licensed adult foster care home that is either not the primary residence of the license holder or in which the license holder is not the primary caregiver, family adult foster care residence, customized living setting, or supervised living facility to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23, in a setting not controlled by a provider, or to receive integrated community supports as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

(o) At the time of reassessment, the certified assessor shall assess each person receiving waiver day services to determine if that person would prefer to receive employment services as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified assessor shall describe to the person through a person-centered planning process the option to receive employment services.

(p) At the time of reassessment, the certified assessor shall assess each person receiving non-self-directed waiver services to determine if that person would prefer an available service and setting option that would permit self-directed services and supports. The certified assessor shall describe to the person through a person-centered planning process the option to receive self-directed services and supports.

(q) All assessments performed according to this subdivision must be face-to-face unless the assessment is a reassessment meeting the requirements of this paragraph. Subject to federal approval, remote reassessments conducted by interactive video or telephone may substitute for face-to-face reassessments for services provided by alternative care under section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities waiver under section 256B.092, and the community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49. Remote reassessments may be substituted for two consecutive reassessments if followed by a face-to-face reassessment. A remote reassessment is permitted only if the person being reassessed, the person's legal representative, and the lead agency case manager all agree that there is no change in the person's condition, there is no need for a change in service,

and that a remote reassessment is appropriate. The person being reassessed, or the person's legal representative, has the right to refuse a remote reassessment at any time. During a remote reassessment, if the certified assessor determines in the assessor's sole judgment that a remote reassessment is inappropriate, the certified assessor shall suspend the remote reassessment and schedule a face-to-face reassessment to complete the reassessment. All other requirements of a face-to-face reassessment apply to a remote reassessment.

Sec. 3. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)

Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most recent assessment. Reassessments must be tailored using the professional judgment of the assessor to the person's known needs, strengths, preferences, and circumstances.

Reassessments provide information to support the person's informed choice and opportunities to express choice regarding activities that contribute to quality of life, as well as information and opportunity to identify goals related to desired employment, community activities, and preferred living environment. Reassessments require a review of the most recent assessment, review of the current coordinated service and support plan's effectiveness, monitoring of services, and the development of an updated person-centered community support plan.

Reassessments must verify continued eligibility, offer alternatives as warranted, and provide an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must be conducted annually or as required by federal and state laws and rules. For reassessments, the certified assessor and the individual responsible for developing the coordinated service and support plan must ensure the continuity of care for the person receiving services and complete the updated community support plan and the updated coordinated service and support plan no more than 60 days from the reassessment visit.

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

Sec. 4. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based service options.

(b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing facility must be screened prior to admission according to the requirements outlined in section 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as required under section 256.975, subdivision 7.

(c) Individuals under 65 years of age who are admitted to nursing facilities with only a telephone screening must receive a face-to-face assessment from the long-term care consultation team member of the county in which the facility is located or from the recipient's county case manager within the timeline established by the commissioner, based on review of data.

(d) At the face-to-face assessment, the long-term care consultation team member or county case manager must perform the activities required under subdivision 3b.

(e) For individuals under 21 years of age, a screening interview which recommends nursing facility admission must be face-to-face and approved by the commissioner before the individual is admitted to the nursing facility.

(f) In the event that an individual under 65 years of age is admitted to a nursing facility on an emergency basis, the Senior LinkAge Line must be notified of the admission on the next working day, and a face-to-face assessment as described in paragraph (c) must be conducted within the timeline established by the commissioner, based on review of data.

(g) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options, including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

(h) An individual under 65 years of age residing in a nursing facility shall receive a ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service choices and available alternatives unless the individual indicates, in writing, that annual visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~ reassessment at least once every 36 months for the same purposes.

(i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who are being considered for placement or residing in a nursing facility.

11.1 (j) Funding for preadmission screening follow-up shall be provided to the Disability
11.2 Hub for the under-60 population by the Department of Human Services to cover options
11.3 counseling salaries and expenses to provide the services described in subdivisions 7a to 7c.
11.4 The Disability Hub shall employ, or contract with other agencies to employ, within the
11.5 limits of available funding, sufficient personnel to provide preadmission screening follow-up
11.6 services and shall seek to maximize federal funding for the service as provided under section
11.7 256.01, subdivision 2, paragraph (aa).

11.8 Sec. 5. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

11.9 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
11.10 conducted by certified assessors according to section 256B.0911, subdivision 2b.

11.11 (b) There must be a determination that the client requires a hospital level of care or a
11.12 nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and
11.13 subsequent assessments to initiate and maintain participation in the waiver program.

11.14 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
11.15 appropriate to determine nursing facility level of care for purposes of medical assistance
11.16 payment for nursing facility services, only ~~face-to-face~~ assessments conducted according
11.17 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
11.18 determination or a nursing facility level of care determination must be accepted for purposes
11.19 of initial and ongoing access to waiver services payment.

11.20 (d) Recipients who are found eligible for home and community-based services under
11.21 this section before their 65th birthday may remain eligible for these services after their 65th
11.22 birthday if they continue to meet all other eligibility factors.

11.23 Sec. 6. Minnesota Statutes 2020, section 256I.05, subdivision 1c, is amended to read:

11.24 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for housing
11.25 support above those in effect on June 30, 1993, except as provided in paragraphs (a) to (f).

11.26 (a) An agency may increase the rates for room and board to the MSA equivalent rate
11.27 for those settings whose current rate is below the MSA equivalent rate.

11.28 (b) An agency may increase the rates for residents in adult foster care whose difficulty
11.29 of care has increased. The total housing support rate for these residents must not exceed the
11.30 maximum rate specified in subdivisions 1 and 1a. Agencies must not include nor increase
11.31 difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding
11.32 by home and community-based waiver programs under title XIX of the Social Security Act.

12.1 (c) The room and board rates will be increased each year when the MSA equivalent rate
12.2 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
12.3 the amount of the increase in the medical assistance personal needs allowance under section
12.4 256B.35.

12.5 (d) When housing support pays for an individual's room and board, or other costs
12.6 necessary to provide room and board, the rate payable to the residence must continue for
12.7 up to 18 calendar days per incident that the person is temporarily absent from the residence,
12.8 not to exceed 60 days in a calendar year, if the absence or absences are reported in advance
12.9 to the county agency's social service staff. Advance reporting is not required for emergency
12.10 absences due to crisis, illness, or injury. For purposes of maintaining housing while
12.11 temporarily absent due to residential behavioral health treatment or health care treatment
12.12 that requires admission to an inpatient hospital, nursing facility, or other health care facility,
12.13 the room and board rate for an individual is payable beyond an 18-calendar-day absence
12.14 period, not to exceed 150 days in a calendar year.

12.15 (e) For facilities meeting substantial change criteria within the prior year. Substantial
12.16 change criteria exists if the establishment experiences a 25 percent increase or decrease in
12.17 the total number of its beds, if the net cost of capital additions or improvements is in excess
12.18 of 15 percent of the current market value of the residence, or if the residence physically
12.19 moves, or changes its licensure, and incurs a resulting increase in operation and property
12.20 costs.

12.21 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
12.22 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
12.23 reside in residences that are licensed by the commissioner of health as a boarding care home,
12.24 but are not certified for the purposes of the medical assistance program. However, an increase
12.25 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
12.26 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
12.27 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
12.28 9549.0058.

12.29 Sec. 7. Minnesota Statutes 2020, section 256J.08, subdivision 21, is amended to read:

12.30 Subd. 21. **Date of application.** "Date of application" means the date on which the county
12.31 agency receives an applicant's ~~signed~~ application as a written application, an application
12.32 submitted by telephone, or an application submitted through Internet telepresence.

13.1 Sec. 8. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

13.2 Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or
13.3 by mail, the application forms prescribed by the commissioner as soon as a person makes
13.4 a written or oral inquiry. At that time, the county agency must:

13.5 (1) inform the person that assistance begins ~~with~~ on the date that the signed application
13.6 is received by the county agency either as a written application; an application submitted
13.7 by telephone; or an application submitted through Internet telepresence; or on the date that
13.8 all eligibility criteria are met, whichever is later;

13.9 (2) inform a person that the person may submit the application by telephone or through
13.10 Internet telepresence;

13.11 (3) inform a person that when the person submits the application by telephone or through
13.12 Internet telepresence, the county agency must receive a signed written application within
13.13 30 days of the date that the person submitted the application by telephone or through Internet
13.14 telepresence;

13.15 (4) inform the person that any delay in submitting the application will reduce the amount
13.16 of assistance paid for the month of application;

13.17 ~~(3)~~ (5) inform a person that the person may submit the application before an interview;

13.18 ~~(4)~~ (6) explain the information that will be verified during the application process by
13.19 the county agency as provided in section 256J.32;

13.20 ~~(5)~~ (7) inform a person about the county agency's average application processing time
13.21 and explain how the application will be processed under subdivision 5;

13.22 ~~(6)~~ (8) explain how to contact the county agency if a person's application information
13.23 changes and how to withdraw the application;

13.24 ~~(7)~~ (9) inform a person that the next step in the application process is an interview and
13.25 what a person must do if the application is approved including, but not limited to, attending
13.26 orientation under section 256J.45 and complying with employment and training services
13.27 requirements in sections 256J.515 to 256J.57;

13.28 ~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may
13.29 be conducted face-to-face in the county office or at a location mutually agreed upon, through
13.30 Internet telepresence, ~~or at a location mutually agreed upon~~ by telephone;

13.31 ~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option~~
13.32 ~~to have a face-to-face, Internet telepresence, or telephone interview;~~

(10) (11) explain the child care and transportation services that are available under paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

(11) (12) identify any language barriers and arrange for translation assistance during appointments, including, but not limited to, screening under subdivision 3a, orientation under section 256J.45, and assessment under section 256J.521.

(b) Upon receipt of a signed application, the county agency must stamp the date of receipt on the face of the application. The county agency must process the application within the time period required under subdivision 5. An applicant may withdraw the application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal. The notice must inform the applicant of the county agency's understanding that the applicant has withdrawn the application and no longer wants to pursue it. When, within ten days of the date of the agency's notice, an applicant informs a county agency, in writing, that the applicant does not wish to withdraw the application, the county agency must reinstate the application and finish processing the application.

(c) Upon a participant's request, the county agency must arrange for transportation and child care or reimburse the participant for transportation and child care expenses necessary to enable participants to attend the screening under subdivision 3a and orientation under section 256J.45.

Sec. 9. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

Subdivision 1. **County agency to provide orientation.** A county agency must provide ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

(1) a single parent, or one parent in a two-parent family, employed at least 35 hours per week; or

(2) a second parent in a two-parent family who is employed for 20 or more hours per week provided the first parent is employed at least 35 hours per week.

The county agency must inform caregivers who are not exempt under clause (1) or (2) that failure to attend the orientation is considered an occurrence of noncompliance with program requirements, and will result in the imposition of a sanction under section 256J.46. If the client complies with the orientation requirement prior to the first day of the month in which the grant reduction is proposed to occur, the orientation sanction shall be lifted.

15.1 Sec. 10. Minnesota Statutes 2020, section 256J.95, subdivision 5, is amended to read:

15.2 Subd. 5. **Submitting application form.** The eligibility date for the diversionary work
15.3 program begins ~~with~~ on the date that the ~~signed~~ combined application form (CAF) is received
15.4 by the county agency, either as a written application, an application submitted by telephone,
15.5 or an application submitted through Internet telepresence, or on the date that diversionary
15.6 work program eligibility criteria are met, whichever is later. The county agency must inform
15.7 an applicant that when the applicant submits the application by telephone or through Internet
15.8 telepresence, the county agency must receive a signed written application within 30 days
15.9 of the date that the applicant submitted the application by telephone or through Internet
15.10 telepresence. The county agency must inform the applicant that any delay in submitting the
15.11 application will reduce the benefits paid for the month of application. The county agency
15.12 must inform a person that an application may be submitted before the person has an interview
15.13 appointment. Upon receipt of a signed application, the county agency must stamp the date
15.14 of receipt on the face of the application. The applicant may withdraw the application at any
15.15 time prior to approval by giving written or oral notice to the county agency. The county
15.16 agency must follow the notice requirements in section 256J.09, subdivision 3, when issuing
15.17 a notice confirming the withdrawal.

15.18 Sec. 11. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

15.19 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
15.20 assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments
15.21 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
15.22 facility level of care determination at initial and subsequent assessments shall be accepted
15.23 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
15.24 service provider's access to service payments under this chapter.