SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2934

(SENATE AUTHORS: HOFFMAN and Abeler)

DATE	D-PG	OFFICIAL STATUS
03/15/2023	1796	Introduction and first reading Referred to Human Services
04/11/2023	4077a	Comm report: To pass as amended and re-refer to Finance
04/17/2023		Comm report: To pass as amended Rule 12.10: report of votes in committee Second reading

A bill for an act

relating to human services; establishing a funding mechanism for a long-term care access fund in the state treasury; establishing an office of addiction and recovery; establishing the Minnesota board of recovery services; establishing title protection for sober homes; modifying provisions governing disability services, aging services, and behavioral health; modifying medical assistance eligibility requirements for certain populations; making technical and conforming changes; establishing certain grants; requiring reports; appropriating money; amending Minnesota Statutes 2022, sections 4.046, subdivisions 6, 7, by adding a subdivision; 16A.151, subdivision 2; 16A.152, subdivisions 1b, 2; 151.065, subdivision 7; 179A.54, by adding a subdivision; 241.021, subdivision 1; 241.31, subdivision 5; 241.415; 245.945; 245A.03, subdivision 7; 245A.11, subdivisions 7, 7a; 245G.01, by adding subdivisions; 245G.02, subdivision 2; 245G.05, subdivision 1, by adding a subdivision; 245G.06, subdivisions 1, 3, 4, by adding subdivisions; 245G.08, subdivision 3; 245G.09, subdivision 3; 245G.22, subdivision 15; 245I.10, subdivision 6; 246.54, subdivisions 1a, 1b; 252.27, subdivision 2a; 254B.01, subdivision 8, by adding subdivisions; 254B.04, by adding a subdivision; 254B.05, subdivisions 1, 5; 256.043, subdivisions 3, 3a; 256.9754; 256B.04, by adding a subdivision; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivisions 17, 17a, 22, by adding a subdivision; 256B.0638, subdivisions 2, 4, 5; 256B.0659, subdivisions 1, 12, 19, 24; 256B.073, subdivision 3, by adding a subdivision; 256B.0759, subdivision 2; 256B.0911, subdivision 13; 256B.0913, subdivisions 4, 5; 256B.0917, subdivision 1b; 256B.0922, subdivision 1; 256B.0949, subdivision 15; 256B.14, subdivision 2; 256B.434, by adding a subdivision; 256B.49, subdivisions 11, 28; 256B.4905, subdivision 5a; 256B.4911, by adding a subdivision; 256B.4912, by adding subdivisions; 256B.4914, subdivisions 3, as amended, 4, 5, 5a, 5b, 5c, 5d, 5e, 8, 9, 10, 10a, 10c, 12, 14, by adding a subdivision; 256B.492; 256B.5012, by adding subdivisions; 256B.766; 256B.85, subdivision 7, by adding a subdivision; 256B.851, subdivisions 5, 6; 256I.05, by adding subdivisions; 256M.42; 256R.02, subdivision 19; 256R.17, subdivision 2; 256R.25; 256R.47; 256R.481; 256R.53, by adding subdivisions; 256S.15, subdivision 2; 256S.18, by adding a subdivision; 256S.19, subdivision 3; 256S.203, subdivisions 1, 2; 256S.205, subdivisions 3, 5; 256S.21; 256S.2101, subdivisions 1, 2, by adding subdivisions; 256S.211, by adding subdivisions; 256S.212; 256S.213; 256S.214; 256S.215, subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17; 289A.20, subdivision 4; 289A.60, subdivision 15; Laws 2019, chapter 63, article 3, section 1, as amended; Laws 2021, First Special Session chapter 7, article 16, section 28, as amended; article 17, sections 16; 20; proposing

coding for new law in Minnesota Statutes, chapters 16A; 121A; 245; 245D; 254B; 256; 256I; 256S; 325F; repealing Minnesota Statutes 2022, sections 245G.05, subdivision 2; 246.18, subdivisions 2, 2a; 256B.0638, subdivisions 1, 2, 3, 4, 5, 6; 256B.0759, subdivision 6; 256B.0917, subdivisions 1a, 6, 7a, 13; 256B.4914, subdivision 9a; 256S.19, subdivision 4.

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

ARTICLE 1
DISABILITY SERVICES

Section 1. Minnesota Statutes 2022, section 16A.152, subdivision 1b, is amended to read:

Subd. 1b. **Budget reserve level.** (a) The commissioner of management and budget shall calculate the budget reserve level by multiplying the current biennium's general fund nondedicated revenues and the most recent budget reserve percentage under subdivision 8.

(b) If, on the basis of a November forecast of general fund revenues and expenditures, the commissioner of management and budget determines that there will be a positive unrestricted general fund balance at the close of the biennium and that the provisions of subdivision 2, paragraph (a), clauses (1)~~, (2), (3), and (4)~~ to (5), are satisfied, the commissioner shall transfer to the budget reserve account in the general fund the amount necessary to increase the budget reserve to the budget reserve level determined under paragraph (a). The amount of the transfer authorized in this paragraph shall not exceed 33 percent of the positive unrestricted general fund balance determined in the forecast.

Sec. 2. Minnesota Statutes 2022, section 16A.152, subdivision 2, is amended to read:

Subd. 2. **Additional revenues; priority.** (a) If on the basis of a forecast of general fund revenues and expenditures, the commissioner of management and budget determines that there will be a positive unrestricted budgetary general fund balance at the close of the biennium, the commissioner of management and budget must allocate money to the following funds, accounts, and purposes in priority order:

(1) the cash flow account established in subdivision 1 until that account reaches $350,000,000;

(2) the long-term care access fund established in section 16A.7241, subdivision 1, until the allocated amount equals the long-term care access fund contribution amount calculated in section 16A.7241, subdivision 2;

~~(2)~~ (3) the budget reserve account established in subdivision 1a until that account reaches $2,377,399,000;

~~(3)~~ (4) the amount necessary to increase the aid payment schedule for school district aids and credits payments in section 127A.45 to not more than 90 percent rounded to the nearest tenth of a percent without exceeding the amount available and with any remaining funds deposited in the budget reserve;

~~(4)~~ (5) the amount necessary to restore all or a portion of the net aid reductions under section 127A.441 and to reduce the property tax revenue recognition shift under section 123B.75, subdivision 5, by the same amount;

~~(5)~~ (6) the amount necessary to increase the Minnesota 21st century fund by not more than the difference between $5,000,000 and the sum of the amounts credited and canceled to it in the previous 12 months under Laws 2020, chapter 71, article 1, section 11, until the sum of all transfers under this section and all amounts credited or canceled under Laws 2020, chapter 71, article 1, section 11, equals $20,000,000; and

~~(6)~~ (7) for a forecast in November only, the amount remaining after the transfer under clause (5) must be used to reduce the percentage of accelerated June liability sales tax payments required under section 289A.20, subdivision 4, paragraph (b), until the percentage equals zero, rounded to the nearest tenth of a percent. By March 15 following the November forecast, the commissioner must provide the commissioner of revenue with the percentage of accelerated June liability owed based on the reduction required by this clause. By April 15 each year, the commissioner of revenue must certify the percentage of June liability owed by vendors based on the reduction required by this clause.

(b) The amounts necessary to meet the requirements of this section are appropriated from the general fund within two weeks after the forecast is released or, in the case of transfers under paragraph (a), clauses ~~(3)~~ (4) and ~~(4)~~ (5), as necessary to meet the appropriations schedules otherwise established in statute.

(c) The commissioner of management and budget shall certify the total dollar amount of the reductions under paragraph (a), clauses ~~(3)~~ (4) and ~~(4)~~ (5), to the commissioner of education. The commissioner of education shall increase the aid payment percentage and reduce the property tax shift percentage by these amounts and apply those reductions to the current fiscal year and thereafter.

Sec. 3. **[16A.7241] LONG-TERM CARE ACCESS FUND.**

Subdivision 1. **Long-term care access fund established.** A long-term care access fund is created in the state treasury. The fund is a direct appropriated special revenue fund. The commissioner shall deposit to the credit of the fund money made available to the fund.

Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the long-term care access fund not currently needed shall be credited to the long-term care access fund.

Subd. 2. **Contribution amount determined.** The commissioner of management and budget must determine the long-term care access fund contribution amount when preparing a forecast. The long-term care access fund contribution amount is equal to any amount greater than zero resulting from subtracting the state share of the projected expenditures for the long-term care facility and long-term care waiver portions of the medical assistance program from the state share of the most recently enacted appropriation from the general fund for these portions of the medical assistance program.

Subd. 3. **Allocation of contribution amount.** If, on the basis of a forecast of general fund revenues and expenditures, the commissioner of management and budget determines that there will be a positive unrestricted budgetary general fund balance at the close of the biennium and that there will be a long-term care access fund contribution amount at the end of the biennium, the commissioner of management and budget must transfer the contribution amount to the long-term care access fund in accordance with the requirements of section 16A.152.

Subd. 4. **Long-term services and supports funding.** The commissioner of human services may expend money appropriated from the long-term care access fund for publicly funded long-term services and supports and for initiatives to prevent or delay the need for Minnesotans to receive publicly funded long-term care services and supports. Money appropriated by law must supplement traditional sources of funding for long-term care services and may not be used as a substitute for forecasted spending.

Sec. 4. Minnesota Statutes 2022, section 179A.54, is amended by adding a subdivision to read:

Subd. 11. **Home Care Orientation Trust.** (a) The state and an exclusive representative certified pursuant to this section may establish a joint labor and management trust, referred to as the Home Care Orientation Trust, for the exclusive purpose of rendering voluntary orientation training to individual providers of direct support services who are represented by the exclusive representative.

(b) Financial contributions by the state to the Home Care Orientation Trust shall be made by the state pursuant to a collective bargaining agreement negotiated under this section. All such financial contributions by the state shall be held in trust for the purpose of paying, from principal, from income, or from both, the costs associated with developing, delivering,

and promoting voluntary orientation training for individual providers of direct support services working under a collective bargaining agreement and providing services through a covered program under section 256B.0711. The Home Care Orientation Trust shall be administered, managed, and otherwise controlled jointly by a board of trustees composed of an equal number of trustees appointed by the state and trustees appointed by the exclusive representative under this section. The trust shall not be an agent of either the state or of the exclusive representative.

(c) Trust administrative, management, legal, and financial services may be provided to the board of trustees by a third-party administrator, financial management institution, other appropriate entity, or any combination thereof, as designated by the board of trustees from time to time, and those services shall be paid from the money held in trust and created by the state's financial contributions to the Home Care Orientation Trust.

(d) The state is authorized to purchase liability insurance for members of the board of trustees appointed by the state.

(e) Financial contributions to, participation in, or both contributions to and participation in the administration, management, or both the administration and management of the Home Care Orientation Trust shall not be considered an unfair labor practice under section 179A.13 or in violation of Minnesota law.

Sec. 5. Minnesota Statutes 2022, section 245.945, is amended to read:

245.945 REIMBURSEMENT TO OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

The commissioner of human services shall obtain federal financial participation for eligible medical assistance administrative activity by the ~~ombudsman for mental health and developmental disabilities~~ Office of Ombudsman for Mental Health and Developmental Disabilities and remit all such money back to the office. The ombudsman shall maintain and transmit to the Department of Human Services documentation that is necessary in order to obtain federal funds.

Sec. 6. Minnesota Statutes 2022, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the

entire period of licensure. If a family child foster care home or family adult foster care home license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. When approving an exception under this paragraph, the commissioner shall consider the resource need determination process in paragraph (h), the availability of foster care licensed beds in the geographic area in which the licensee seeks to operate, the results of a person's choices during their annual assessment and service plan review, and the recommendation of the local county board. The determination by the commissioner is final and not subject to appeal. Exceptions to the moratorium include:

(1) foster care settings where at least 80 percent of the residents are 55 years of age or older;

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

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

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

(5) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 or elderly waiver plan under chapter 256S and residing in the customized living setting ~~before July 1, 2022,~~ for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for

reconsideration is final and not subject to appeal under chapter 14. The exception is available until ~~June 30~~ December 31, 2023. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people ~~under the brain injury or community access for disability inclusion waiver plans under section 256B.49~~ in a single-family home operational on or before June 30, 2021. Operational is defined in section 256B.49, subdivision 28;

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

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

(6) new foster care licenses or community residential setting licenses for a customized living setting that is a single-family home in which customized living or 24-hour customized living services were authorized and delivered on June 30, 2021, under the brain injury or community access for disability inclusion waiver plans under section 256B.49 or the elderly waiver under chapter 256S and for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available for any eligible setting licensed as an assisted living facility under chapter 144G on or after August 1, 2021, if the assisted living licensee applies for a license under chapter 245D before December 31, 2023. The initial licensed capacity of the setting under this exception must be four. This exception is available when:

(i) the case manager of each resident of the customized living setting provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice about remaining in the newly licensed setting; and

(ii) the estimated average cost of services provided in the licensed foster care or community residential setting is less than or equal to the estimated average cost of services delivered in the customized living setting as determined by the lead agency.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which

the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

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

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

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

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

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

services licensing division that the license holder provides or intends to provide these waiver-funded services.

(h) The commissioner may adjust capacity to address needs identified in section 144A.351. Under this authority, the commissioner may approve new licensed settings or delicense existing settings. Delicensing of settings will be accomplished through a process identified in section 256B.493.

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

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

EFFECTIVE DATE. This section is effective retroactively from July 1, 2021.

Sec. 7. Minnesota Statutes 2022, section 245A.11, subdivision 7, is amended to read:

Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow for alternative methods of overnight supervision. The commissioner may grant the variance if the local county licensing agency recommends the variance and the county recommendation includes documentation verifying that:

(1) the county has approved the license holder's plan for alternative methods of providing overnight supervision and determined the plan protects the residents' health, safety, and rights;

(2) the license holder has obtained written and signed informed consent from each resident or each resident's legal representative documenting the resident's or legal representative's agreement with the alternative method of overnight supervision; and

(3) the alternative method of providing overnight supervision, which may include the use of technology, is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

(b) To be eligible for a variance under paragraph (a), the adult foster care license holder must not have had a conditional license issued under section 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

(c) A license holder requesting a variance under this subdivision to utilize technology as a component of a plan for alternative overnight supervision may request the commissioner's review in the absence of a county recommendation. Upon receipt of such a request from a license holder, the commissioner shall review the variance request with the county.

(d) ~~A variance granted by the commissioner according to this subdivision before January 1, 2014, to a license holder for an adult foster care home must transfer with the license when the license converts to a community residential setting license under chapter 245D. The terms and conditions of the variance remain in effect as approved at the time the variance was granted~~ The variance requirements under this subdivision for alternative overnight supervision do not apply to community residential settings licensed under chapter 245D.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 245A.11, subdivision 7a, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care ~~and community residential setting~~ licenses.** (a) The commissioner may grant an applicant or license holder an adult foster care ~~or community residential setting~~ license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder when an incident occurs that

may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under chapter 245D, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

(1) that the facility is under electronic monitoring; and

(2) the telephone number of the county's common entry point for making reports of suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the county licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

(c) Before a license is issued by the commissioner, and for the duration of the license, the applicant or license holder must establish, maintain, and document the implementation of written policies and procedures addressing the requirements in paragraphs (d) through (f).

(d) The applicant or license holder must have policies and procedures that:

(1) establish characteristics of target populations that will be admitted into the home, and characteristics of populations that will not be accepted into the home;

(2) explain the discharge process when a resident served by the program requires overnight supervision or other services that cannot be provided by the license holder due to the limited hours that the license holder is on site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2). The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill to be conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of residents served by the program:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the resident served by the program without requiring the initiation of the foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each resident's individualized plan of care, support plan under sections 256B.0913, subdivision 8; 256B.092, subdivision 1b; 256B.49, subdivision 15; and 256S.10, if required,

or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that resident.

(f) Each resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care ~~or community residential setting~~ license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

(1) how any electronic monitoring is incorporated into the alternative supervision system;

(2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;

(3) how the caregivers or direct support staff are trained on the use of the technology;

(4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects each resident's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

(6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

(i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning under section 245A.02, subdivision 9, and additionally includes all staff, volunteers, and contractors affiliated with the license holder.

(j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely determine what action the license holder needs to take to protect the well-being of the foster care recipient.

(k) The commissioner shall evaluate license applications using the requirements in paragraphs (d) to (f). The commissioner shall provide detailed application forms, including a checklist of criteria needed for approval.

(l) To be eligible for a license under paragraph (a), the adult foster care ~~or community residential setting~~ license holder must not have had a conditional license issued under section 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home ~~or community residential setting~~.

(m) The commissioner shall review an application for an alternative overnight supervision license within 60 days of receipt of the application. When the commissioner receives an application that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05. The commissioner shall complete subsequent review within 30 days.

(n) Once the application is considered complete under paragraph (m), the commissioner will approve or deny an application for an alternative overnight supervision license within 60 days.

(o) For the purposes of this subdivision, "supervision" means:

(1) oversight by a caregiver or direct support staff as specified in the individual resident's place agreement or support plan and awareness of the resident's needs and activities; and

(2) the presence of a caregiver or direct support staff in a residence during normal sleeping hours, unless a determination has been made and documented in the individual's support

plan that the individual does not require the presence of a caregiver or direct support staff during normal sleeping hours.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. **[245D.261] COMMUNITY RESIDENTIAL SETTINGS; REMOTE OVERNIGHT SUPERVISION.**

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

(b) "Resident" means an adult residing in a community residential setting.

(c) "Technology" means:

(1) enabling technology, which is a device capable of live two-way communication or engagement between a resident and direct support staff at a remote location; or

(2) monitoring technology, which is the use of equipment to oversee, monitor, and supervise an individual who receives medical assistance waiver or alternative care services under section 256B.0913, 256B.092, or chapter 256S.

Subd. 2. **Documentation of permissible remote overnight supervision.** A license holder providing remote overnight supervision in a community residential setting in lieu of on-site direct support staff must comply with the requirements of this chapter, including the requirement under section 245D.02, subdivision 33b, paragraph (a), clause (3), that the absence of direct support staff from the community residential setting while services are being delivered must be documented in the resident's support plan or support plan addendum.

Subd. 3. **Provider requirements for remote overnight supervision; commissioner notification.** (a) A license holder providing remote overnight supervision in a community residential setting must:

(1) use technology;

(2) notify the commissioner of the community residential setting's intent to use technology in lieu of on-site staff. The notification must:

(i) indicate a start date for the use of technology; and

(ii) attest that all requirements under this section are met and policies required under subdivision 4 are available upon request;

(3) clearly state in each person's support plan addendum that the community residential setting is a program without the in-person presence of overnight direct support;

(4) include with each person's support plan addendum the license holder's protocols for responding to situations that present a serious risk to the health, safety, or rights of residents served by the program; and

(5) include in each person's support plan addendum the person's maximum permissible response time as determined by the person's support team.

(b) Upon being notified via technology that an incident has occurred that may jeopardize the health, safety, or rights of a resident, the license holder must conduct an evaluation of the need for the physical presence of a staff member. If a physical presence is needed, a staff person, volunteer, or contractor must be on site to respond to the situation within the resident's maximum permissible response time.

(c) A license holder must notify the commissioner if remote overnight supervision technology will no longer be used by the license holder.

(d) Upon receipt of notification of use of remote overnight supervision or discontinuation of use of remote overnight supervision by a license holder, the commissioner shall notify the county licensing agency and update the license.

Subd. 4. **Required policies and procedures for remote overnight supervision.** (a) A license holder providing remote overnight supervision must have policies and procedures that:

(1) protect the residents' health, safety, and rights;

(2) explain the discharge process if a person served by the program requires in-person supervision or other services that cannot be provided by the license holder due to the limited hours that direct support staff are on site;

(3) explain the backup system for technology in times of electrical outages or other equipment malfunctions;

(4) explain how the license holder trains the direct support staff on the use of the technology; and

(5) establish a plan for dispatching emergency response personnel to the site in the event of an identified emergency.

(b) Nothing in this section requires the license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards if the requirements of this section are incorporated into those documents.

(c) When no physical presence response is completed for a three-month period, the license holder must conduct a physical presence response drill. The effectiveness of the response protocol must be reviewed and documented.

Subd. 5. **Consent to use of monitoring technology.** If a license holder uses monitoring technology in a community residential setting, the license holder must obtain a signed informed consent form from each resident served by the program or the resident's legal representative documenting the resident's or legal representative's agreement to use of the specific monitoring technology used in the setting. The informed consent form documenting this agreement must also explain:

(1) how the license holder uses monitoring technology to provide remote supervision;

(2) the risks and benefits of using monitoring technology;

(3) how the license holder protects each resident's privacy while monitoring technology is being used in the setting; and

(4) how the license holder protects each resident's privacy when the monitoring technology system electronically records personally identifying data.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 10. **[256.4761] PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED COMMUNITIES.**

Subdivision 1. **Establishment and authority.** (a) The commissioner of human services shall award grants to organizations that provide community-based services to rural or underserved communities. The grants must be used to build organizational capacity to provide home and community-based services in the state and to build new or expanded infrastructure to access medical assistance reimbursement.

(b) The commissioner shall conduct community engagement, provide technical assistance, and establish a collaborative learning community related to the grants available under this section and shall work with the commissioner of management and budget and the commissioner of the Department of Administration to mitigate barriers in accessing grant money.

(c) The commissioner shall limit expenditures under this subdivision to the amount appropriated for this purpose.

(d) The commissioner shall give priority to organizations that provide culturally specific and culturally responsive services or that serve historically underserved communities throughout the state.

Subd. 2. **Eligibility.** An eligible applicant for the capacity grants under subdivision 1 is an organization or provider that serves, or will serve, rural or underserved communities and:

(1) provides, or will provide, home and community-based services in the state; or

(2) serves, or will serve, as a connector for communities to available home and community-based services.

Subd. 3. **Allowable grant activities.** Grants under this section must be used by recipients for the following activities:

(1) expanding existing services;

(2) increasing access in rural or underserved areas;

(3) creating new home and community-based organizations;

(4) connecting underserved communities to benefits and available services; or

(5) building new or expanded infrastructure to access medical assistance reimbursement.

Sec. 11. **[256.4762] LONG-TERM CARE WORKFORCE GRANTS FOR NEW AMERICANS.**

Subdivision 1. **Definition.** For the purposes of this section, "new American" means an individual born abroad and the individual's children, irrespective of immigration status.

Subd. 2. **Grant program established.** The commissioner of human services shall establish a grant program for organizations that support immigrants, refugees, and new Americans interested in entering the long-term care workforce.

Subd. 3. **Eligibility.** (a) The commissioner shall select projects for funding under this section. An eligible applicant for the grant program in subdivision 1 is an:

(1) organization or provider that is experienced in working with immigrants, refugees, and people born outside of the United States and that demonstrates cultural competency; or

(2) organization or provider with the expertise and capacity to provide training, peer mentoring, supportive services, and workforce development or other services to develop and implement strategies for recruiting and retaining qualified employees.

(b) The commissioner shall prioritize applications from joint labor management programs.

Subd. 4. **Allowable grant activities.** (a) Money allocated under this section must be used to:

(1) support immigrants, refugees, or new Americans to obtain or maintain employment in the long-term care workforce;

(2) develop connections to employment with long-term care employers and potential employees;

(3) provide recruitment, training, guidance, mentorship, and other support services necessary to encourage employment, employee retention, and successful community integration;

(4) provide career education, wraparound support services, and job skills training in high-demand health care and long-term care fields;

(5) pay for program expenses, including but not limited to hiring instructors and navigators, space rentals, and supportive services to help participants attend classes. Allowable uses for supportive services include but are not limited to:

(i) course fees;

(ii) child care costs;

(iii) transportation costs;

(iv) tuition fees;

(v) financial coaching fees;

(vi) mental health supports; or

(vii) uniforms costs incurred as a direct result of participating in classroom instruction or training; or

(6) repay student loan debt directly incurred as a result of pursuing a qualifying course of study or training.

Sec. 12. **[256.4763] AWARENESS-BUILDING CAMPAIGN FOR THE RECRUITMENT OF DIRECT CARE PROFESSIONALS.**

Subdivision 1. **Grant program established.** The commissioner of employment and economic development shall develop and implement paid advertising as part of a

comprehensive awareness-building campaign aimed at recruiting direct care professionals to provide long-term care services.

Subd. 2. **Definition.** For purposes of this section, "direct care professionals" means long-term care services employees who provide direct support or care to people using aging, disability, or behavioral health services.

Subd. 3. **Request for proposals; allowable uses of grant money.** (a) The commissioner shall publish a request for proposals to select an outside vendor or vendors to conduct the awareness-building campaign for the recruitment of direct care professionals.

(b) Grant money received under this section may be used:

(1) for the development of recruitment materials for the direct care workforce to be featured on:

(i) television;

(ii) streaming services;

(iii) radio;

(iv) social media;

(v) billboards; and

(vi) other print materials;

(2) for the development of materials and strategies to highlight and promote the positive aspects of the direct care workforce;

(3) purchase of media time or space to feature recruitment materials for the direct care workforce; and

(4) for administrative costs necessary to implement this grant program.

(c) The Department of Employment and Economic Development may collaborate with relevant state agencies for the purposes of the development and implementation of this campaign and is authorized to transfer administrative money to such agencies to cover any associated administrative costs.

Sec. 13. **[256.4764] HOME AND COMMUNITY-BASED WORKFORCE INCENTIVE FUND GRANTS.**

Subdivision 1. **Grant program established.** The commissioner of human services shall establish grants for disability and home and community-based providers to assist with recruiting and retaining direct support and frontline workers.

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

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

(c) "Eligible employer" means an organization enrolled in a Minnesota health care program or providing housing services and that is:

(1) a provider of home and community-based services under chapter 245D; or

(2) a facility certified as an intermediate care facility for persons with developmental disabilities.

(d) "Eligible worker" means a worker who earns $30 per hour or less and is currently employed or recruited to be employed by an eligible employer.

Subd. 3. **Allowable uses of grant money.** (a) Grantees must use grant money to provide payments to eligible workers for the following purposes:

(1) retention, recruitment, and incentive payments;

(2) postsecondary loan and tuition payments;

(3) child care costs;

(4) transportation-related costs; and

(5) other costs associated with retaining and recruiting workers, as approved by the commissioner.

(b) Eligible workers may receive payments up to $1,000 per year from the home and community-based workforce incentive fund.

(c) The commissioner must develop a grant cycle distribution plan that allows for equitable distribution of money among eligible employers. The commissioner's determination of the grant awards and amounts is final and is not subject to appeal.

Subd. 4. **Attestation.** As a condition of obtaining grant payments under this section, an eligible employer must attest and agree to the following:

(1) the employer is an eligible employer;

(2) the total number of eligible employees;

(3) the employer will distribute the entire value of the grant to eligible workers, as allowed under this section;

(4) the employer will create and maintain records under subdivision 6;

(5) the employer will not use the money appropriated under this section for any purpose other than the purposes permitted under this section; and

(6) the entire value of any grant amounts will be distributed to eligible workers identified by the employer.

Subd. 5. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after a grant is awarded to ensure:

(1) the grantee used the money solely for allowable purposes under subdivision 3;

(2) the grantee was truthful when making attestations under subdivision 4; and

(3) the grantee complied with the conditions of receiving a grant under this section.

(b) If the commissioner determines that a grantee used grant money for purposes not authorized under this section, the commissioner must treat any amount used for a purpose not authorized under this section as an overpayment. The commissioner must recover any overpayment.

Subd. 6. **Grants not to be considered income.** (a) For the purposes of this subdivision, "subtraction" has the meaning given in section 290.0132, subdivision 1, paragraph (a), and the rules in that subdivision apply to this subdivision. The definitions in section 290.01 apply to this subdivision.

(b) The amount of a grant award received under this section is a subtraction.

(c) Grant awards under this section are excluded from income, as defined in sections 290.0674, subdivision 2a, and 290A.03, subdivision 3.

(d) Notwithstanding any law to the contrary, grant awards under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under chapter 119B;

(2) general assistance, Minnesota supplemental aid, and food support under chapter 256D;

(3) housing support under chapter 256I;

(4) the Minnesota family investment program and diversionary work program under chapter 256J; and

(5) economic assistance programs under chapter 256P.

(e) The commissioner must not consider grant awards under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a), 3, or 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, or 3b.

Sec. 14. **[256.4771] SUPPORTED-DECISION-MAKING PROGRAMS.**

Subdivision 1. **Authorization.** The commissioner of human services shall award general operating grants to public and private nonprofit organizations, counties, and Tribes to provide and promote supported decision making.

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

(b) "Supported decision making" has the meaning given in section 524.5-102, subdivision 16a.

(c) "Supported-decision-making services" means services provided to help an individual consider, access, or develop supported decision making, potentially as an alternative to more restrictive forms of decision making, including guardianship and conservatorship. The services may be provided to the individual, family members, or trusted support people. The individual may currently be a person subject to guardianship or conservatorship, but the services must not be used to help a person access a guardianship or conservatorship.

Subd. 3. **Grants.** (a) The grants must be distributed as follows:

(1) at least 75 percent of the grant money must be used to fund programs or organizations that provide supported-decision-making services;

(2) no more than 20 percent of the grant money may be used to fund county or Tribal programs that provide supported-decision-making services; and

(3) no more than five percent of the grant money may be used to fund programs or organizations that do not provide supported-decision-making services but do promote the use and advancement of supported decision making.

(b) The grants must be distributed in a manner to promote racial and geographic diversity in the populations receiving services as determined by the commissioner.

Subd. 4. **Evaluation and report.** By December 1, 2024, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy an interim report on the impact and outcomes of the grants, including the number of grants awarded and the organizations receiving the grants. The interim report must include any available evidence of how grantees were able to increase utilization of supported decision making and reduce or avoid more restrictive forms of decision making such as guardianship and conservatorship. By December 1, 2025, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy a final report on the impact and outcomes of the grants, including any updated information from the interim report and the total number of people served by the grants. The final report must also detail how the money was used to achieve the requirements in subdivision 3, paragraph (b).

Subd. 5. **Applications.** Any public or private nonprofit agency may apply to the commissioner for a grant under subdivision 3, paragraph (a), clause (1) or (3). Any county or Tribal agency in Minnesota may apply to the commissioner for a grant under subdivision 3, paragraph (a), clause (2). The application must be submitted in a form approved by the commissioner.

Subd. 6. **Duties of grantees.** Every public or private nonprofit agency, county, or Tribal agency that receives a grant to provide or promote supported decision making must comply with rules related to the administration of the grants.

Sec. 15. **[256.4773] TECHNOLOGY FOR HOME GRANT.**

Subdivision 1. **Establishment.** The commissioner must establish a technology for home grant program that provides assistive technology consultations and resources for people with disabilities who want to stay in their own home, move to their own home, or remain in a less restrictive residential setting. The grant program may be administered using a team approach that allows multiple professionals to assess and meet a person's assistive technology needs. The team may include but is not limited to occupational therapists, physical therapists, speech therapists, nurses, and engineers.

Subd. 2. **Eligible applicants.** An eligible applicant is a person who uses or is eligible for home care services under section 256B.0651, home and community-based services under section 256B.092 or 256B.49, personal care assistance under section 256B.0659, or community first services and supports under section 256B.85, and who meets one of the following conditions:

(1) lives in the applicant's own home and may benefit from assistive technology for safety, communication, community engagement, or independence;

(2) is currently seeking to live in the applicant's own home and needs assistive technology to meet that goal; or

(3) resides in a residential setting under section 256B.4914, subdivision 3, and is seeking to reduce reliance on paid staff to live more independently in the setting.

Subd. 3. **Allowable grant activities.** The technology for home grant program must provide at-home, in-person assistive technology consultation and technical assistance to help people with disabilities live more independently. Allowable activities include but are not limited to:

(1) consultations in people's homes, workplaces, or community locations;

(2) connecting people to resources to help them live in their own homes, transition to their own homes, or live more independently in residential settings;

(3) conduct training and set-up and installation of assistive technology; and

(4) participate on a person's care team to develop a plan to ensure assistive technology goals are met.

Subd. 4. **Data collection and outcomes.** Grantees must provide data summaries to the commissioner for the purpose of evaluating the effectiveness of the grant program. The commissioner must identify outcome measures to evaluate program activities to assess whether the grant programs help people transition to or remain in the least restrictive setting.

Sec. 16. Minnesota Statutes 2022, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression ~~towards~~ toward self, others, or destruction of property that requires the immediate response of another person.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires assistance to begin and complete one or more of the activities of daily living.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under chapter 256S and sections 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be reduced; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community. For purposes of this paragraph, traveling includes driving and accompanying the recipient in the recipient's chosen mode of transportation and according to the recipient's personal care assistance care plan.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes

a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

EFFECTIVE DATE. This section is effective 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 17. Minnesota Statutes 2022, section 256B.0659, subdivision 12, is amended to read:

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

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

(7) any shared care provided, if applicable;

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

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

(10) any time spent traveling, as described in subdivision 1, paragraph (i), including start and stop times with a.m. and p.m. designations, the origination site, and the destination site.

EFFECTIVE DATE. This section is effective 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2022, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

(6) engage in an annual reassessment as required in subdivision 3a to determine continuing eligibility and service authorization; ~~and~~

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

(8) ensure that a personal care assistant driving the recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 19. Minnesota Statutes 2022, section 256B.0659, subdivision 24, is amended to read:

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

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

(2) comply with general medical assistance coverage requirements;

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

(4) comply with background study requirements;

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

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

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

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

(9) 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;

(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;

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

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

(17) ensure that a personal care assistant driving a recipient under subdivision 1, paragraph (i), has a valid driver's license and the vehicle used is registered and insured according to Minnesota law.

EFFECTIVE DATE. This section is effective 90 days following federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256B.0911, subdivision 13, is amended to read:

Subd. 13. **MnCHOICES assessor qualifications, training, and certification.** (a) The commissioner shall develop and implement a curriculum and an assessor certification process.

(b) MnCHOICES certified assessors must:

(1) either have a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field ~~with at least one year of home and community-based experience~~ or be a registered nurse with at least two years of home and community-based experience; and

(2) have received training and certification specific to assessment and consultation for long-term care services in the state.

(c) Certified assessors shall demonstrate best practices in assessment and support planning, including person-centered planning principles, and have a common set of skills that ensures consistency and equitable access to services statewide.

(d) Certified assessors must be recertified every three years.

Sec. 21. Minnesota Statutes 2022, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

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

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

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

(ii) a bachelor's degree in a behavioral health, child development, or related field including, but not limited to, mental health, special education, social work, psychology,

speech pathology, or occupational therapy, from an accredited college or university, and advanced certification in a treatment modality recognized by the department;

(iii) a board-certified behavior analyst; or

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

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

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

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

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

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

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

(2) a person who has:

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

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

(3) a person who has at least 4,000 hours of supervised clinical experience in delivering treatment to people with ASD or a related condition. Hours worked as a mental health

behavioral aide or level III treatment provider may be included in the required hours of experience; or

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

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

(i) is fluent in a non-English language or is an individual certified by a Tribal Nation;

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

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

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

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

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

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

(4) completion of all required EIDBI training within six months of employment.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2022, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the federal Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

(1) promote the support of persons with disabilities in the most integrated settings;

(2) expand the availability of services for persons who are eligible for medical assistance;

(3) promote cost-effective options to institutional care; and

(4) obtain federal financial participation.

(b) The provision of waiver services to medical assistance recipients with disabilities shall comply with the requirements outlined in the federally approved applications for home and community-based services and subsequent amendments, including provision of services according to a service plan designed to meet the needs of the individual, except when applying a size limitation to a setting, the commissioner must treat residents under 55 years of age who are receiving services under the brain injury or the community access for disability inclusion waiver as if the residents are 55 years of age or older if the residents lived and received services in the setting on or before March 1, 2023. For purposes of this section, the approved home and community-based application is considered the necessary federal requirement.

(c) The commissioner shall provide interested persons serving on agency advisory committees, task forces, the Centers for Independent Living, and others who request to be on a list to receive, notice of, and an opportunity to comment on, at least 30 days before any effective dates, (1) any substantive changes to the state's disability services program manual, or (2) changes or amendments to the federally approved applications for home and community-based waivers, prior to their submission to the federal Centers for Medicare and Medicaid Services.

(d) The commissioner shall seek approval, as authorized under section 1915(c) of the federal Social Security Act, to allow medical assistance eligibility under this section for children under age 21 without deeming of parental income or assets.

(e) The commissioner shall seek approval, as authorized under section 1915(c) of the Social Act, to allow medical assistance eligibility under this section for individuals under age 65 without deeming the spouse's income or assets.

(f) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section, except when applying a size limitation to a setting, the commissioner must treat residents under 55 years of age who are receiving services under the brain injury or the community access for disability inclusion waiver as if the residents are 55 years of age or older if the residents lived and received services in the setting on or before March 1, 2023.

(g) The commissioner shall seek federal approval to allow for the reconfiguration of the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement a two-waiver program structure.

(h) The commissioner shall seek federal approval for the 1915(c) home and community-based waivers in this section, as authorized under section 1915(c) of the federal Social Security Act, to implement an individual resource allocation methodology.

EFFECTIVE DATE. This section is effective retroactively from January 11, 2021.

Sec. 23. Minnesota Statutes 2022, section 256B.49, subdivision 28, is amended to read:

Subd. 28. **Customized living moratorium for brain injury and community access for disability inclusion waivers.** (a) Notwithstanding section 245A.03, subdivision 2, paragraph (a), clause (23), to prevent new development of customized living settings that otherwise meet the residential program definition under section 245A.02, subdivision 14, the commissioner shall not enroll new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined under the brain injury or community access for disability inclusion waiver plans under this section.

(b) The commissioner may approve an exception to paragraph (a) when an existing customized living setting changes ownership at the same address and must approve an exception to paragraph (a) when the same owner relocates an existing customized living setting to a new address.

(c) Customized living settings operational on or before June 30, 2021, are considered existing customized living settings.

(d) For any new customized living settings serving four or fewer people in a single-family home to deliver customized living services as defined in paragraph (a) and that was not operational on or before June 30, 2021, the authorizing lead agency is financially responsible for all home and community-based service payments in the setting.

(e) For purposes of this subdivision, "operational" means customized living services are authorized and delivered to a person in the customized living setting.

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

Sec. 24. Minnesota Statutes 2022, section 256B.4905, subdivision 5a, is amended to read:

Subd. 5a. **Employment first implementation for disability waiver services.** (a) The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all working-age Minnesotans with disabilities can work and achieve competitive integrated employment with appropriate services and supports, as needed; and

(2) each waiver recipient of working age be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to work and earn a competitive wage before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

(b) Nothing in this subdivision prohibits a waiver recipient of working age, after an informed decision-making process and during a person-centered planning process, from choosing employment at a special minimum wage under a 14(c) certificate as provided by Code of Federal Regulations, title 29, sections 525.1 to 525.24. For any waiver recipient who chooses employment at a special minimum wage, the commissioner must not impose any limitations on the length of disability services provided to support the recipient's informed choice or limitations on the reimbursement rates for the disability waiver services provided to support the recipient's informed choice.

Sec. 25. Minnesota Statutes 2022, section 256B.4911, is amended by adding a subdivision to read:

Subd. 6. **Services provided by parents and spouses.** (a) This subdivision limits medical assistance payments under the consumer-directed community supports option for personal assistance services provided by a parent to the parent's minor child or by a participant's spouse. This subdivision applies to the consumer-directed community supports option available under all of the following:

(1) alternative care program;

(2) brain injury waiver;

(3) community alternative care waiver;

(4) community access for disability inclusion waiver;

(5) developmental disabilities waiver;

(6) elderly waiver; and

(7) Minnesota senior health option.

(b) For the purposes of this subdivision, "parent" means a parent, stepparent, or legal guardian of a minor.

(c) If multiple parents are providing personal assistance services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. The total number of hours of personal assistance services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(d) If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of personal assistance services in a seven-day period regardless of the number of children served.

(e) If a participant's spouse is providing personal assistance services, the spouse may provide up to 60 hours of personal assistance services in a seven-day period.

(f) This subdivision must not be construed to permit an increase in the total authorized consumer-directed community supports budget for an individual.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 26. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision to read:

Subd. 1b. **Direct support professional annual labor market survey.** (a) The commissioner shall develop and administer a survey of direct care staff who work for organizations that provide services under the following programs:

(1) home and community-based services for seniors under chapter 256S and section 256B.0913, home and community-based services for people with developmental disabilities under section 256B.092, and home and community-based services for people with disabilities under section 256B.49;

(2) personal care assistance services under section 256B.0625, subdivision 19a; community first services and supports under section 256B.85; nursing services and home health services under section 256B.0625, subdivision 6a; home care nursing services under section 256B.0625, subdivision 7; and

(3) financial management services for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0659, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community

alternative care waiver, the community access for disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in subdivision 1a, clauses (7) to (11).

(b) The survey must collect information about the individual experience of the direct-care staff and any other information necessary to assess the overall economic viability and well-being of the workforce.

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

(d) Individually identifiable data submitted to the commissioner under this section are considered private data on individuals as defined by section 13.02, subdivision 12.

(e) The commissioner shall analyze data submitted under this section annually to assess the overall economic viability and well-being of the workforce and the impact of the state of workforce on access to services.

Sec. 27. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision to read:

Subd. 1c. **Annual labor market report.** The commissioner shall publish annual reports on provider and state-level labor market data, including but not limited to the data outlined in subdivisions 1a and 1b.

Sec. 28. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision to read:

Subd. 16. **Rates established by the commissioner.** For homemaker services eligible for reimbursement under the developmental disabilities waiver, the brain injury waiver, the community alternative care waiver, and the community access for disability inclusion waiver, the commissioner must establish rates equal to the rates established under sections 256S.21 to 256S.215 for the corresponding homemaker services.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 29. Minnesota Statutes 2022, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) night supervision;

(16) positive support services;

(17) prevocational services;

(18) residential support services;

(19) ~~respite services;~~

~~(20)~~ transportation services; and

~~(21)~~ (20) other services as approved by the federal government in the state home and community-based services waiver plan.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2022, section 256B.4914, subdivision 4, is amended to read:

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

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

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

(1) shared staffing hours;

(2) individual staffing hours;

(3) direct registered nurse hours;

(4) direct licensed practical nurse hours;

(5) staffing ratios;

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

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

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

(9) service hours provided through monitoring technology.

(d) Updates to individual data must include:

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

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

(e) Lead agencies shall review and approve all services reflecting each individual's needs, and the values to calculate the final payment rate for services with variables under subdivisions 6 to ~~9a~~ 9 for each individual. Lead agencies must notify the individual and the service provider of the final agreed-upon values and rate, and provide information that is identical to what was entered into the rates management system. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests. When responding to the request, the lead agency must consider:

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

(2) meeting the requirements for staffing under subdivision 2, paragraphs (h), (n), and (o); and meeting or exceeding the licensing standards for staffing required under section 245D.09, subdivision 1; and

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

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 31. Minnesota Statutes 2022, section 256B.4914, subdivision 5, is amended to read:

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

(b) The commissioner shall update the base wage index in subdivision 5a, publish these updated values, and load them into the rate management system as follows:

(1) on January 1, 2022, based on wage data by SOC from the Bureau of Labor Statistics available as of December 31, 2019; and

~~(2) on November 1, 2024, based on wage data by SOC from the Bureau of Labor Statistics available as of December 31, 2021; and~~

~~(3)~~ (2) on ~~July 1, 2026~~ January 1, 2024, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics available ~~30~~ 24 months and one day prior to the scheduled update.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 32. Minnesota Statutes 2022, section 256B.4914, subdivision 5a, is amended to read:

Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as follows:

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

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

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

(4) for residential asleep-overnight staff, the minimum wage in Minnesota for large employers, with the exception of asleep-overnight staff for family residential services, which is 36 percent of the minimum wage in Minnesota for large employers;

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

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code ~~31-1014~~ 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC code 31-1131); and 30 percent of the median wage for home health and personal care aide (SOC code 31-1120);

(7) for day support services staff and prevocational services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for positive supports analyst staff, 100 percent of the median wage for ~~substance abuse, behavioral disorder, and mental health counselor~~ clinical, counseling, and school psychologists (SOC code ~~21-1018~~ 19-3031);

(9) for positive supports professional staff, 100 percent of the median wage for ~~clinical counseling and school~~ psychologist, all other (SOC code ~~19-3031~~ 19-3039);

(10) for positive supports specialist staff, 100 percent of the median wage for ~~psychiatric technicians~~ occupational therapist (SOC code ~~29-2053~~ 29-1122);

(11) for individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1131); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

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

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

(14) for employment exploration services staff, 50 percent of the median wage for ~~rehabilitation counselor (SOC code 21-1015)~~ education, guidance, school, and vocational counselor (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

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

(16) for individualized home support without training staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the median wage for nursing assistant (SOC code 31-1131); and

(17) for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and.

~~(18) for respite staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1131); and 50 percent of the median wage for nursing assistant (SOC code 31-1014).~~

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2022, section 256B.4914, subdivision 5b, is amended to read:

Subd. 5b. **Standard component value adjustments.** The commissioner shall update the client and programming support, transportation, and program facility cost component values as required in subdivisions 6 to ~~9a~~ 9 for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower, publish these updated values, and load them into the rate management system as follows:

(1) on January 1, 2022, by the percentage change in the CPI-U from the date of the previous update to the data available on December 31, 2019; and

~~(2) on November 1, 2024, by the percentage change in the CPI-U from the date of the previous update to the data available as of December 31, 2021; and~~

~~(3)~~ (2) on ~~July~~ January 1, ~~2026~~ 2024, and every two years thereafter, by the percentage change in the CPI-U from the date of the previous update to the data available ~~30~~ 12 months and one day prior to the scheduled update.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 34. Minnesota Statutes 2022, section 256B.4914, subdivision 5c, is amended to read:

Subd. 5c. **Removal of after-framework adjustments.** Any rate adjustments applied to the service rates calculated under this section outside of the cost components and rate methodology specified in this section shall be removed from rate calculations upon implementation of the updates under subdivisions 5 ~~and~~, 5b, and 5f.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 35. Minnesota Statutes 2022, section 256B.4914, subdivision 5d, is amended to read:

Subd. 5d. **Unavailable data for updates and adjustments.** If Bureau of Labor Statistics occupational codes or Consumer Price Index items specified in subdivision 5 ~~or~~, 5b, or 5f are unavailable in the future, the commissioner shall recommend to the legislature codes or items to update and replace.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 36. Minnesota Statutes 2022, section 256B.4914, subdivision 5e, is amended to read:

Subd. 5e. **Inflationary update spending requirement.** (a) At least 80 percent of the marginal increase in revenue from the rate ~~adjustment applied to the service rates~~ adjustments calculated under subdivisions 5 and ~~5b beginning on January 1, 2022,~~ 5f for services rendered ~~between January 1, 2022, and March 31, 2024,~~ on or after the day of implementation of the adjustment must be used to increase compensation-related costs for employees directly employed by the program ~~on or after January 1, 2022~~.

(b) For the purposes of this subdivision, compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's paid share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to ~~January 1, 2022~~ implementation of the applicable rate adjustment, including retention and recruitment bonuses and tuition reimbursement.

(c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider, or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives a rate subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of a rate adjustment subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner or commissioner's representative if an employee believes the employee has not received the compensation-related increase described in the plan.

~~(e) This subdivision expires June 30, 2024~~.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 37. Minnesota Statutes 2022, section 256B.4914, is amended by adding a subdivision to read:

Subd. 5f. **Competitive workforce factor adjustments.** (a) On January 1, 2024, and every two years thereafter, the commissioner shall update the competitive workforce factor to equal the differential between:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential support services and direct care staff for day programs; and

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations.

(b) For each update of the competitive workforce factor, the update must not decrease the competitive workforce factor by more than 2.0. If the competitive workforce factor is less than or equal to zero, then the competitive workforce factor is zero.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 38. Minnesota Statutes 2022, section 256B.4914, subdivision 8, is amended to read:

Subd. 8. **Unit-based services with programming; component values and calculation of payment rates.** (a) For the purpose of this section, unit-based services with programming include employment exploration services, employment development services, employment support services, individualized home supports with family training, individualized home supports with training, and positive support services provided to an individual outside of any service plan for a day program or residential support service.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

(6) client programming and support ratio: 4.7 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

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

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

(c) A unit of service for unit-based services with programming is 15 minutes.

(d) Payments for unit-based services with programming must be calculated as follows, unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for services provided in a shared manner, divide the total payment in clause (13) as follows:

(i) for employment exploration services, divide by the number of service recipients, not to exceed five;

(ii) for employment support services, divide by the number of service recipients, not to exceed six; and

(iii) for individualized home supports with training and individualized home supports with family training, divide by the number of service recipients, not to exceed ~~two~~ three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39. Minnesota Statutes 2022, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Unit-based services without programming; component values and calculation of payment rates.** (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite.

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

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

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

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

(c) A unit of service for unit-based services without programming is 15 minutes.

(d) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet a recipient's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 to 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring customization for deaf and hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for program plan support, multiply the result of clause (7) by one plus the program plan support ratio;

(9) for employee-related expenses, multiply the result of clause (8) by one plus the employee-related cost ratio;

(10) for client programming and supports, multiply the result of clause (9) by one plus the client programming and support ratio;

(11) this is the subtotal rate;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount;

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed ~~two~~ three; and

(15) adjust the result of clause (14) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 40. Minnesota Statutes 2022, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. **Evaluation of information and data.** (a) The commissioner shall, within available resources, conduct research and gather data and information from existing state systems or other outside sources on the following items:

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

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

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

(b) The commissioner, in consultation with stakeholders, shall review and evaluate the following values already in subdivisions 6 to ~~9a~~ 9, or issues that impact all services, including, but not limited to:

(1) values for transportation rates;

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

(3) values for indirect services;

(4) values for nursing;

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

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

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

(8) direct care workforce labor market measures;

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

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

(11) different competitive workforce factors by service, as determined under subdivision 10b.

(c) The commissioner shall report to the chairs and the ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance with the information and data gathered under paragraphs (a) and (b) on January 15, 2021, with a full report, and a full report once every four years thereafter.

(d) Beginning July 1, 2022, the commissioner shall renew analysis and implement changes to the regional adjustment factors once every six years. Prior to implementation, the commissioner shall consult with stakeholders on the methodology to calculate the adjustment.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. Minnesota Statutes 2022, section 256B.4914, subdivision 10a, is amended to read:

Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure that wage values and component values in subdivisions 5 to ~~9a~~ 9 reflect the cost to provide the service. As determined by the commissioner, in consultation with stakeholders identified in subdivision 17, a provider enrolled to provide services with rates determined under this section must submit requested cost data to the commissioner to support research on the cost of providing services that have rates determined by the disability waiver rates system. Requested cost data may include, but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy.

(d) The commissioner shall analyze cost data submitted under paragraph (a) and, in consultation with stakeholders identified in subdivision 17, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services once every four years beginning January 1, 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (c).

(e) The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.

(f) The commissioner, in consultation with stakeholders identified in subdivision 17, shall develop and implement a process for providing training and technical assistance necessary to support provider submission of cost documentation required under paragraph (a).

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 42. Minnesota Statutes 2022, section 256B.4914, subdivision 10c, is amended to read:

Subd. 10c. **Reporting and analysis of competitive workforce factor.** (a) Beginning February 1, ~~2021~~ 2025, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance an analysis of the competitive workforce factor.

(b) The report must include ~~recommendations to update the competitive workforce factor using~~:

(1) the most recently available wage data by SOC code for the weighted average wage for direct care staff for residential services and direct care staff for day services;

(2) the most recently available wage data by SOC code of the weighted average wage of comparable occupations; and

(3) workforce data as required under subdivision 10b.

(c) ~~The commissioner shall not recommend an increase or decrease of the competitive workforce factor from the current value by more than two percentage points. If, after a biennial analysis for the next report, the competitive workforce factor is less than or equal to zero, the commissioner shall recommend a competitive workforce factor of zero.~~ This subdivision expires upon submission of the calendar year 2030 report.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 43. Minnesota Statutes 2022, section 256B.4914, subdivision 12, is amended to read:

Subd. 12. **Customization of rates for individuals.** (a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6 to ~~9a~~ 9. The customization rate with respect to deaf or hard-of-hearing persons shall be $2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means:

(1) the person has a developmental disability and:

(i) an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(ii) an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative communication aid, or does not have functional communication, or the person's expressive communications is unknown; and

(iii) a communication score which indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication, or that the person's receptive communication score is unknown; or

(2) the person receives long-term care services and has an assessment score that indicates the person hears only very loud sounds, the person has no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 44. Minnesota Statutes 2022, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

(b) Lead agencies must act on an exception request within 30 days and notify the initiator of the request of their recommendation in writing. A lead agency shall submit all exception requests along with its recommendation to the commissioner.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service;

(2) an individual's rate determined under subdivisions 6 to ~~9a~~ 9 is so insufficient that it has resulted in an individual receiving a notice of discharge from the individual's provider; or

(3) an individual's service needs, including behavioral changes, require a level of service which necessitates a change in provider or which requires the current provider to propose service changes beyond those currently authorized.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6 to ~~9a~~ 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6 to ~~9a~~ 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation; and

(4) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients, an interested party, or the license holder that would receive the rate exception increase may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient, interested party, or license holder of its decision and the reasons for denying the request in writing no later than 30 days after the request has been made and shall submit its denial to the commissioner in accordance with paragraph (b). The reasons for the denial must be based on the failure to meet the criteria in paragraph (c).

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient, the interested party, and the license holder in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. When the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

(j) The starting date for the rate exception will be the later of the date of the recipient's change in support or the date of the request to the lead agency for an exception.

(k) The commissioner shall track all exception requests received and their dispositions. The commissioner shall issue quarterly public exceptions statistical reports, including the number of exception requests received and the numbers granted, denied, withdrawn, and pending. The report shall include the average amount of time required to process exceptions.

(l) Approved rate exceptions remain in effect in all cases until an individual's needs change as defined in paragraph (c).

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 45. Minnesota Statutes 2022, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) home and community-based settings that comply with:

(i) all requirements identified by the federal Centers for Medicare and Medicaid Services in the Code of Federal Regulations, title 42, section 441.301(c),; and

~~with~~ (ii) the requirements of the federally approved transition plan and waiver plans for each home and community-based services waiver except when applying a size limitation to a setting, the commissioner must treat residents under 55 years of age who are receiving services under the brain injury or the community access for disability inclusion waiver as if the residents are 55 years of age or older if the residents lived and received services in the setting on or before March 1, 2023; and

(2) settings required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service

plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

Sec. 46. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision to read:

Subd. 19. **ICF/DD rate increase effective July 1, 2023.** (a) Effective July 1, 2023, the daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is increased by $50.

(b) Effective July 1, 2023, the daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is increased by $50.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision to read:

Subd. 20. **ICF/DD minimum daily operating payment rates.** (a) The minimum daily operating payment rate for a class A intermediate care facility for persons with developmental disabilities is $300.

(b) The minimum daily operating payment rate for a class B intermediate care facility for persons with developmental disabilities is $400.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 48. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision to read:

Subd. 21. **Spending requirements.** (a) At least 80 percent of the marginal increase in revenue resulting from implementation of the rate increases under subdivisions 19 and 20 for services rendered on or after the day of implementation of the increases must be used to increase compensation-related costs for employees directly employed by the facility.

(b) For the purposes of this subdivision, compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's paid share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to implementation of the rate increases.

(c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider, or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives additional revenue subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of the new rate methodology or any rate adjustment subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee has not received the compensation-related increase described in the plan.

Sec. 49. Minnesota Statutes 2022, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan; and

(ii) increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

(6) services provided by a consultation services provider as defined under subdivision 17, that is under contract with the department and enrolled as a Minnesota health care program provider;

(7) services provided by an FMS provider as defined under subdivision 13a, that is an enrolled provider with the department;

(8) CFSS services provided by a support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. ~~These support workers shall not:~~ Covered services under this clause are subject to the limitations described in subdivision 7b; and

~~(i) provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents providing services, combination of parents and spouses providing services, or number of children who receive medical assistance services; and~~

~~(ii) have a wage that exceeds the current rate for a CFSS support worker including the wage, benefits, and payroll taxes; and~~

(9) worker training and development services as described in subdivision 18a.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 50. Minnesota Statutes 2022, section 256B.85, is amended by adding a subdivision to read:

Subd. 7b. **Services provided by parents and spouses.** (a) This subdivision applies to services and supports described in subdivision 7, clause (8).

(b) If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(c) If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

(d) If a participant's spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.

(e) Paragraphs (b) to (d) must not be construed to permit an increase in either the total authorized service budget for an individual or the total number of authorized service units.

(f) A parent or participant's spouse must not receive a wage that exceeds the current rate for a CFSS support worker, including wages, benefits, and payroll taxes.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 51. Minnesota Statutes 2022, section 256B.851, subdivision 5, is amended to read:

Subd. 5. **Payment rates; component values.** (a) The commissioner must use the following component values:

(1) employee vacation, sick, and training factor, 8.71 percent;

(2) employer taxes and workers' compensation factor, 11.56 percent;

(3) employee benefits factor, 12.04 percent;

(4) client programming and supports factor, 2.30 percent;

(5) program plan support factor, 7.00 percent;

(6) general business and administrative expenses factor, 13.25 percent;

(7) program administration expenses factor, 2.90 percent; and

(8) absence and utilization factor, 3.90 percent.

(b) For purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: ~~75.45 percent;~~ 88.19 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: ~~75.45~~ 88.19 percent; and

(3) qualified professional services and CFSS worker training and development: ~~75.45~~ 88.19 percent.

(c) Effective January 1, 2025, for purposes of implementation, the commissioner shall use the following implementation components:

(1) personal care assistance services and CFSS: 92.10 percent;

(2) enhanced rate personal care assistance services and enhanced rate CFSS: 92.10 percent; and

(3) qualified professional services and CFSS worker training and development: 92.10 percent.

(d) Beginning January 1, 2025, the commissioner shall use the following worker retention components:

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is zero percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 2.17 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 4.36 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 7.35 percent; and

(5) for workers who have provided more than 10,000 hours in personal care assistance services or CFSS, the worker retention component is 10.81 percent.

(e) The commissioner shall define the appropriate worker retention component based on the total number of units billed for services rendered by the individual provider since July 1, 2017. The worker retention component must be determined by the commissioner for each individual provider and is not subject to appeal.

EFFECTIVE DATE. The amendments to paragraph (b) are effective January 1, 2024, or 90 days after federal approval, whichever is later. Paragraph (b) expires January 1, 2025, or 90 days after federal approval of paragraph (c), whichever is later. Paragraphs (c), (d), and (e) are effective January 1, 2025, or 90 days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 52. Minnesota Statutes 2022, section 256B.851, subdivision 6, is amended to read:

Subd. 6. **Payment rates; rate determination.** (a) The commissioner must determine the rate for personal care assistance services, CFSS, extended personal care assistance services, extended CFSS, enhanced rate personal care assistance services, enhanced rate CFSS, qualified professional services, and CFSS worker training and development as follows:

(1) multiply the appropriate total wage component value calculated in subdivision 4 by one plus the employee vacation, sick, and training factor in subdivision 5;

(2) for program plan support, multiply the result of clause (1) by one plus the program plan support factor in subdivision 5;

(3) for employee-related expenses, add the employer taxes and workers' compensation factor in subdivision 5 and the employee benefits factor in subdivision 5. The sum is employee-related expenses. Multiply the product of clause (2) by one plus the value for employee-related expenses;

(4) for client programming and supports, multiply the product of clause (3) by one plus the client programming and supports factor in subdivision 5;

(5) for administrative expenses, add the general business and administrative expenses factor in subdivision 5, the program administration expenses factor in subdivision 5, and the absence and utilization factor in subdivision 5;

(6) divide the result of clause (4) by one minus the result of clause (5). The quotient is the hourly rate;

(7) multiply the hourly rate by the appropriate implementation component under subdivision 5. This is the adjusted hourly rate; and

(8) divide the adjusted hourly rate by four. The quotient is the total adjusted payment rate.

(b) In processing claims, the commissioner shall incorporate a staff retention component as specified under subdivision 5 by multiplying the total adjusted payment rate by one plus the appropriate staff retention component under subdivision 5. This is the total payment rate.

~~(b)~~ (c) The commissioner must publish the total ~~adjusted~~ final payment rates.

EFFECTIVE DATE. This section is effective January 1, 2025, or ninety days after federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 53. Minnesota Statutes 2022, section 256S.2101, subdivision 1, is amended to read:

Subdivision 1. **Phase-in for disability waiver customized living rates.** All rates and rate components for community access for disability inclusion customized living and brain injury customized living under section 256B.4914 ~~shall~~ must be the sum of ~~ten~~ 21.6 percent of the rates calculated under sections 256S.211 to 256S.215 and ~~90~~ 78.4 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 54. Minnesota Statutes 2022, section 289A.20, subdivision 4, is amended to read:

Subd. 4. **Sales and use tax.** (a) The taxes imposed by chapter 297A are due and payable to the commissioner monthly on or before the 20th day of the month following the month in which the taxable event occurred, or following another reporting period as the commissioner prescribes or as allowed under section 289A.18, subdivision 4, paragraph (f) or (g), except that use taxes due on an annual use tax return as provided under section 289A.11, subdivision 1, are payable by April 15 following the close of the calendar year.

(b) A vendor having a liability of $250,000 or more during a fiscal year ending June 30, except a vendor of construction materials as defined in paragraph (e), must remit the June liability for the next year in the following manner:

(1) Two business days before June 30 of calendar year 2020 and 2021, the vendor must remit 87.5 percent of the estimated June liability to the commissioner. Two business days before June 30 of calendar year 2022 and thereafter, the vendor must remit 84.5 percent, or a reduced percentage as certified by the commissioner under section 16A.152, subdivision 2, paragraph (a), clause ~~(6)~~ (7), of the estimated June liability to the commissioner.

(2) On or before August 20 of the year, the vendor must pay any additional amount of tax not remitted in June.

(c) A vendor having a liability of:

(1) $10,000 or more, but less than $250,000, during a fiscal year must remit by electronic means all liabilities on returns due for periods beginning in all subsequent calendar years on or before the 20th day of the month following the month in which the taxable event occurred, or on or before the 20th day of the month following the month in which the sale is reported under section 289A.18, subdivision 4; or

(2) $250,000 or more during a fiscal year must remit by electronic means all liabilities in the manner provided in paragraph (a) on returns due for periods beginning in the subsequent calendar year, except that a vendor subject to the remittance requirements of paragraph (b) must remit the percentage of the estimated June liability, as provided in paragraph (b), clause (1), which is due two business days before June 30. The remaining amount of the June liability is due on August 20.

(d) Notwithstanding paragraph (b) or (c), a person prohibited by the person's religious beliefs from paying electronically shall be allowed to remit the payment by mail. The filer must notify the commissioner of revenue of the intent to pay by mail before doing so on a form prescribed by the commissioner. No extra fee may be charged to a person making payment by mail under this paragraph. The payment must be postmarked at least two business days before the due date for making the payment in order to be considered paid on a timely basis.

(e) For the purposes of paragraph (b), "vendor of construction materials" means a retailer that sells any of the following construction materials, if 50 percent or more of the retailer's sales revenue for the fiscal year ending June 30 is from the sale of those materials:

(1) lumber, veneer, plywood, wood siding, wood roofing;

(2) millwork, including wood trim, wood doors, wood windows, wood flooring; or

(3) concrete, cement, and masonry.

(f) Paragraph (b) expires after the percentage of estimated payment is reduced to zero in accordance with section 16A.152, subdivision 2, paragraph (a), clause ~~(6)~~ (7).

Sec. 55. Minnesota Statutes 2022, section 289A.60, subdivision 15, is amended to read:

Subd. 15. **Accelerated payment of June sales tax liability; penalty for underpayment.** (a) For payments made after December 31, 2019, and before December

31, 2021, if a vendor is required by law to submit an estimation of June sales tax liabilities and 87.5 percent payment by a certain date, the vendor shall pay a penalty equal to ten percent of the amount of actual June liability required to be paid in June less the amount remitted in June. The penalty must not be imposed, however, if the amount remitted in June equals the lesser of 87.5 percent of the preceding May's liability or 87.5 percent of the average monthly liability for the previous calendar year.

(b) For payments made after December 31, 2021, the penalty must not be imposed if the amount remitted in June equals the lesser of 84.5 percent, or a reduced percentage as certified by the commissioner under section 16A.152, subdivision 2, paragraph (a), clause ~~(6)~~ (7), of the preceding May's liability or 84.5 percent of the average monthly liability for the previous calendar year.

(c) This subdivision expires after the percentage of estimated payment is reduced to zero in accordance with section 16A.152, subdivision 2, paragraph (a), clause ~~(6)~~ (7).

Sec. 56. Laws 2021, First Special Session chapter 7, article 17, section 16, is amended to read:

Sec. 16. **RESEARCH ON ACCESS TO LONG-TERM CARE SERVICES AND FINANCING.**

(a) This act includes $400,000 in fiscal year 2022 and $300,000 in fiscal year 2023 for an actuarial research study of public and private financing options for long-term services and supports reform to increase access across the state. Any unexpended amount in fiscal year 2023 is available through June 30, 2024. The commissioner of human services must conduct the study. Of this amount, the commissioner may transfer up to $100,000 to the commissioner of commerce for costs related to the requirements of the study. The general fund base included in this act for this purpose is $0 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All activities must be completed by June 30, 2024.

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

Sec. 57. Laws 2021, First Special Session chapter 7, article 17, section 20, is amended to read:

Sec. 20. **HCBS WORKFORCE DEVELOPMENT GRANT.**

Subdivision 1. **Appropriation.** (a) This act includes $0 in fiscal year 2022 and ~~$5,588,000~~ $0 in fiscal year 2023 to address challenges related to attracting and maintaining direct care workers who provide home and community-based services for people with disabilities and older adults. The general fund base included in this act for this purpose is ~~$5,588,000~~ $11,176,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) At least 90 percent of funding for this provision must be directed to workers who earn ~~200~~ 300 percent or less of the most current federal poverty level issued by the United States Department of Health and Human Services.

(c) The commissioner must consult with stakeholders to finalize a report detailing the final plan for use of the funds. The commissioner must publish the report by March 1, 2022, and notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Subd. 2. **Public assistance eligibility.** Notwithstanding any law to the contrary, workforce development grant money received under this section is not income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under Minnesota Statutes, chapter 119B;

(2) general assistance, Minnesota supplemental aid, and food support under Minnesota Statutes, chapter 256D;

(3) housing support under Minnesota Statutes, chapter 256I;

(4) the Minnesota family investment program and diversionary work program under Minnesota Statutes, chapter 256J; and

(5) economic assistance programs under Minnesota Statutes, chapter 256P.

Subd. 3. **Medical assistance eligibility.** Notwithstanding any law to the contrary, workforce development grant money received under this section is not income or assets for the purposes of determining eligibility for medical assistance under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (a), 3, or 3c; or 256B.057, subdivision 3, 3a, 3b, 4, or 9.

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

Sec. 58. **MEMORANDUMS OF UNDERSTANDING.**

The memorandums of understanding with Service Employees International Union Healthcare Minnesota and Iowa, submitted by the commissioner of management and budget on February 27, 2023, are ratified.

Sec. 59. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

The labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota and Iowa, submitted to the Legislative Coordinating Commissioner on February 27, 2023, is ratified.

Sec. 60. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

(a) Effective January 1, 2024, or upon federal approval, whichever is later, consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, must be increased by 8.49 percent.

(b) Effective January 1, 2025, or upon federal approval, whichever is later, consumer-directed community support budgets identified in the waiver plans under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S; and the alternative care program under Minnesota Statutes, section 256B.0913, must be increased by 4.53 percent.

Sec. 61. **DIRECT CARE SERVICE CORPS PILOT PROJECT.**

Subdivision 1. **Establishment.** The Metropolitan Center for Independent Living must develop a pilot project establishing the Minnesota Direct Care Service Corps. The pilot project must utilize financial incentives to attract postsecondary students to work as personal care assistants or direct support professionals. The Metropolitan Center for Independent Living must establish the financial incentives and minimum work requirements to be eligible for incentive payments. The financial incentive must increase with each semester that the student participates in the Minnesota Direct Care Service Corps.

Subd. 2. **Pilot sites.** (a) Pilot sites must include one postsecondary institution in the seven-county metropolitan area and at least one postsecondary institution outside of the seven-county metropolitan area. If more than one postsecondary institution outside the metropolitan area is selected, one must be located in northern Minnesota and the other must be located in southern Minnesota.

(b) After satisfactorily completing the work requirements for a semester, the pilot site or its fiscal agent must pay students the financial incentive developed for the pilot project.

Subd. 3. **Evaluation and report.** (a) The Metropolitan Center for Independent Living must contract with a third party to evaluate the pilot project's impact on health care costs, retention of personal care assistants, and patients' and providers' satisfaction of care. The evaluation must include the number of participants, the hours of care provided by participants, and the retention of participants from semester to semester.

(b) By January 15, 2025, the Metropolitan Center for Independent Living must report the findings under paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance.

Sec. 62. **EMERGENCY GRANT PROGRAM FOR AUTISM SPECTRUM DISORDER TREATMENT AGENCIES.**

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

(b) "Autism spectrum disorder" has the meaning given to "autism spectrum disorder or a related condition" in Minnesota Statutes, section 256B.0949, subdivision 2, paragraph (d).

(c) "Autism spectrum disorder treatment services" means treatment delivered under Minnesota Statutes, section 256B.0949.

(d) "Qualified early intensive developmental and behavioral intervention agency" or "qualified EIDBI agency" has the meaning given in Minnesota Statutes, section 256B.0949, subdivision 2, paragraph (c).

Subd. 2. **Emergency grant program for autism spectrum disorder treatment agencies.** The commissioner of human services shall award emergency grant money to eligible qualified EIDBI agencies to support the stability of the autism spectrum disorder treatment provider sector.

Subd. 3. **Eligible agencies.** Qualified EIDBI agencies that have been delivering autism spectrum disorder treatment services for a minimum of six months are eligible to receive emergency grants under this section.

Subd. 4. **Allocation of grants.** (a) Eligible agencies must apply for a grant under this section on an application in the form specified by the commissioner, which at a minimum must contain:

(1) a description of the purpose or project for which grant money will be used;

(2) a description of the specific problem the grant money will address;

(3) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(4) a process for documenting and evaluating results of the grant.

(b) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications, the commissioner shall establish criteria, including but not limited to:

(1) the eligibility of the project;

(2) the applicant's thoroughness and clarity in describing the problem grant money is intended to address;

(3) a description of the applicant's proposed project;

(4) a description of the population demographics and service area of the proposed project;

(5) the manner in which the applicant will demonstrate the effectiveness of any projects undertaken;

(6) the proposed project's longevity and demonstrated financial sustainability after the initial grant period; and

(7) the evidence of efficiencies and effectiveness gained through collaborative efforts.

(c) The commissioner may consider other relevant factors in addition to those listed in paragraph (b).

(d) In evaluating applications, the commissioner may request from the applicant additional information regarding a proposed project, including information on project costs. An applicant's failure to provide the information requested disqualifies an applicant.

(e) The commissioner shall determine the number of grants awarded.

(f) The commissioner shall award grants to eligible agencies through December 31, 2025.

Subd. 5. **Eligible uses of grant money.** The commissioner shall develop a list of eligible uses for grants awarded under this section.

Sec. 63. **RATE INCREASE FOR CERTAIN HOME CARE SERVICES.**

(a) Effective January 1, 2024, or upon federal approval, whichever is later, the commissioner of human services must increase payment rates for home health aide visits by 14 percent from the rates in effect on December 31, 2023. The commissioner must apply the annual rate increases under Minnesota Statutes, section 256B.0653, subdivision 8, to the rates resulting from the application of the rate increases under this paragraph.

(b) Effective January 1, 2024, or upon federal approval, whichever is later, the commissioner must increase payment rates for respiratory therapy under Minnesota Rules, part 9505.0295, subpart 2, item E, and for home health services and home care nursing services, except home health aide visits, under Minnesota Statutes, section 256B.0651, subdivision 2, clauses (1) to (3), by 55 percent from the rates in effect on December 31, 2023. The commissioner must apply the annual rate increases under Minnesota Statutes, sections 256B.0653, subdivision 8, and 256B.0654, subdivision 5, to the rates resulting from the application of the rate increase under this paragraph.

Sec. 64. **SPECIALIZED EQUIPMENT AND SUPPLIES LIMIT INCREASE.**

Upon federal approval, the commissioner must increase the annual limit for specialized equipment and supplies under Minnesota's federally approved home and community-based service waiver plans, alternative care, and essential community supports to $10,000.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 65. **STUDY TO EXPAND ACCESS TO SERVICES FOR PEOPLE WITH CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS AND DISABILITIES.**

The commissioner, in consultation with stakeholders, must evaluate options to expand services authorized under Minnesota's federally approved home and community-based waivers, including positive support, crisis respite, respite, and specialist services. The evaluation may include surveying community providers as to the barriers to meeting people's needs and options to authorize services under Minnesota's medical assistance state plan and strategies to decrease the number of people who remain in hospitals, jails, and other acute or crisis settings when they no longer meet medical or other necessity criteria.

Sec. 66. **TEMPORARY GRANT FOR SMALL CUSTOMIZED LIVING PROVIDERS.**

(a) The commissioner must establish a temporary grant for:

(1) customized living providers that serve six or fewer people in a single-family home and that are transitioning to a community residential services licensure or integrated community supports licensure; and

(2) community residential service providers and integrated community supports providers who transitioned from providing customized living or 24-hour customized living on or after June 30, 2021.

(b) Allowable uses of grant money include physical plant updates required for community residential services or integrated community supports licensure, technical assistance to adapt business models and meet policy and regulatory guidance, and other uses approved by the commissioner. Allowable uses of grant money also include reimbursement for eligible costs incurred by a community residential service provider or integrated community supports provider directly related to the provider's transition from providing customized living or 24-hour customized living. License holders of eligible settings must apply for grant money using an application process determined by the commissioner. Grant money approved by the commissioner is a onetime award of up to $20,000 per eligible setting. To be considered for grant money, eligible license holders must submit a grant application by June 30, 2024. The commissioner may approve grant applications on a rolling basis.

Sec. 67. **DIRECTION TO COMMISSIONER; SUPPORTED-DECISION-MAKING REIMBURSEMENT STUDY.**

By December 15, 2024, the commissioner shall issue a report to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over human services detailing how medical assistance service providers could be reimbursed for providing supported-decision-making services. The report must detail recommendations for all medical assistance programs, including all home and community-based programs, to provide for reimbursement for supported-decision-making services. The report must develop detailed provider requirements for reimbursement, including the criteria necessary to provide high-quality services. In developing provider requirements, the commissioner shall consult with all relevant stakeholders, including organizations currently providing supported-decision-making services. The report must also include strategies to promote equitable access to supported-decision-making services to individuals who are Black, Indigenous, or People of Color; people from culturally-specific communities; people from

rural communities; and other people who may experience barriers to accessing medical assistance home and community-based services.

Sec. 68. **DIRECTION TO COMMISSIONER; APPLICATION OF INTERMEDIATE CARE FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES RATE INCREASES.**

The commissioner of human services shall apply the rate increases under Minnesota Statutes, section 256B.5012, subdivisions 19 and 20, as follows:

(1) apply Minnesota Statutes, section 256B.5012, subdivision 19; and

(2) apply any required rate increase as required under Minnesota Statutes, section 256B.5012, subdivision 20, to the results of clause (1).

Sec. 69. **DIRECTION TO COMMISSIONER; SHARED SERVICES.**

(a) By December 1, 2023, the commissioner of human services shall seek any necessary changes to home and community-based services waiver plans regarding sharing services in order to:

(1) permit shared services for additional services, including chore, homemaker, and night supervision;

(2) permit existing shared services at higher ratios, including individualized home supports without training, individualized home supports with training, and individualized home supports with family training at a ratio of one staff person to three recipients;

(3) ensure that individuals who are seeking to share services permitted under the waiver plans in an own-home setting are not required to live in a licensed setting in order to share services so long as all other requirements are met; and

(4) issue guidance for shared services, including:

(i) informed choice for all individuals sharing the services;

(ii) guidance for when multiple shared services by different providers occur in one home and how lead agencies and individuals shall determine that shared service is appropriate to meet the needs, health, and safety of each individual for whom the lead agency provides case management or care coordination; and

(iii) guidance clarifying that an individual's decision to share services does not reduce any determination of the individual's overall or assessed needs for services.

(b) The commissioner shall develop or provide guidance outlining:

(1) instructions for shared services support planning;

(2) person-centered approaches and informed choice in shared services support planning; and

(3) required contents of shared services agreements.

(c) The commissioner shall seek and utilize stakeholder input for any proposed changes to waiver plans and any shared services guidance.

Sec. 70. **DIRECTION TO COMMISSIONER; DISABILITY WAIVER SHARED SERVICES RATES.**

The commissioner of human services shall establish a rate system for shared homemaker services and shared chore services provided under Minnesota Statutes, sections 256B.092 and 256B.49. For two persons sharing services, the rate paid to a provider must not exceed 1-1/2 times the rate paid for serving a single individual, and for three persons sharing services, the rate paid to a provider must not exceed two times the rate paid for serving a single individual. These rates apply only when all of the criteria for the shared service have been met.

Sec. 71. **DIRECTION TO COMMISSIONER; LIFE-SHARING SERVICES.**

Subdivision 1. **Recommendations required.** The commissioner of human services shall develop recommendations for establishing life sharing as a covered medical assistance waiver service.

Subd. 2. **Definition.** For the purposes of this section, "life sharing" means a relationship-based living arrangement between an adult with a disability and an individual or family in which they share their lives and experiences while the adult with a disability receives support from the individual or family using person-centered practices.

Subd. 3. **Stakeholder engagement and consultation.** (a) The commissioner must proactively solicit participation in the development of the life-sharing medical assistance service through a robust stakeholder engagement process that results in the inclusion of a racially, culturally, and geographically diverse group of interested stakeholders from each of the following groups:

(1) providers currently providing or interested in providing life-sharing services;

(2) people with disabilities accessing or interested in accessing life-sharing services;

(3) disability advocacy organizations; and

(4) lead agencies.

(b) The commissioner must proactively seek input into and assistance with the development of recommendations for establishing the life-sharing service from interested stakeholders.

(c) The first meeting must occur before July 31, 2023. The commissioner must meet with stakeholders at least monthly through December 31, 2023. All meetings must be accessible.

Subd. 4. **Required topics to be discussed during development of the recommendations.** The commissioner and the interested stakeholders must discuss the following topics:

(1) the distinction between life sharing, adult family foster care, family residential services, and community residential services;

(2) successful life-sharing models used in other states;

(3) services and supports that could be included in a life-sharing service;

(4) potential barriers to providing or accessing life-sharing services;

(5) solutions to remove identified barriers to providing or accessing life-sharing services;

(6) requirements of a life-sharing agency;

(7) medical assistance payment methodologies for life-sharing providers and life-sharing agencies;

(8) expanding awareness of the life-sharing model; and

(9) draft language for legislation necessary to further define and implement life-sharing services.

Subd. 5. **Report to the legislature.** By December 31, 2023, the commissioner must provide to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over direct care services any draft legislation necessary to implement the rates and requirements for life-sharing services.

Sec. 72. **DIRECTION TO COMMISSIONER; FOSTER CARE MORATORIUM EXCEPTION APPLICATIONS.**

(a) The commissioner must expedite the processing and review of all new and pending applications for an initial foster care or community residential setting license under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clauses (5) and (6).

(b) The commissioner must include on the application materials for an initial foster care or community residential setting license under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clauses (5) and (6), an opportunity for applicants to signify that they are seeking an initial foster care or community residential setting license in order to transition an existing operational customized living setting to a foster care or community residential setting. Operational has the meaning given in section 256B.49, subdivision 28, paragraph (e).

(c) For any pending applications for a license under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clause (5), the commissioner must determine if the applicant is eligible for an exception under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clause (6), and if so, act upon the application under clause (6) rather than clause (5).

(d) The commissioner must increase to four the licensed capacity of any setting for which the commissioner issued a license under Minnesota Statutes, section 245A.03, subdivision 7, paragraph (a), clause (5), before the final enactment of this act.

(e) This section expires June 30, 2023.

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

Sec. 73. **REPEALER.**

Minnesota Statutes 2022, section 256B.4914, subdivision 9a, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 2
AGING SERVICES

Section 1. Minnesota Statutes 2022, section 256.9754, is amended to read:

256.9754 ~~COMMUNITY SERVICES DEVELOPMENT~~ LIVE WELL AT HOME GRANTS ~~PROGRAM~~.

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

(a) "Community" means a town, township, city, or targeted neighborhood within a city, or a consortium of towns, townships, cities, or targeted neighborhoods within cities.

(b) "Core home and community-based services provider" means a Faith in Action, Living at Home/Block Nurse, congregational nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.

(c) "Long-term services and supports" means any service available under the elderly waiver program or alternative care grant programs, nursing facility services, transportation services, caregiver support and respite care services, and other home and community-based services identified as necessary either to maintain lifestyle choices for older adults or to support them to remain in their own home.

~~(b)~~ (d) "Older adult services" means any services available under the elderly waiver program or alternative care grant programs; nursing facility services; transportation services; respite services; and other community-based services identified as necessary either to maintain lifestyle choices for older Minnesotans, or to promote independence.

~~(c)~~ (e) "Older adult" refers to individuals 65 years of age and older.

Subd. 2. **Creation; purpose.** (a) The ~~community services development~~ live well at home grants ~~program is~~ are created under the administration of the commissioner of human services.

(b) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older adults and people with dementia, including statewide capacity for local service development and technical assistance and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports in

Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

(1) reach older adults early in the progression of their need for long-term services and supports, providing them with low-cost, high-impact services that will prevent or delay the use of more costly services;

(2) support older adults to live in the most integrated, least restrictive community setting;

(3) support the informal caregivers of older adults;

(4) develop and implement strategies to integrate long-term services and supports with health care services, in order to improve the quality of care and enhance the quality of life of older adults and their informal caregivers;

(5) ensure cost-effective use of financial and human resources;

(6) build community-based approaches and community commitment to delivering long-term services and supports for older adults in their own homes;

(7) achieve a broad awareness and use of lower-cost in-home services as an alternative to nursing homes and other residential services;

(8) strengthen and develop additional home and community-based services and alternatives to nursing homes and other residential services; and

(9) strengthen programs that use volunteers.

(c) The services provided by these projects are available to older adults who are eligible for medical assistance and the elderly waiver under chapter 256S, the alternative care program under section 256B.0913, or the essential community supports grant under section 256B.0922, and to persons who have their own money to pay for services.

Subd. 3. **~~Provision of~~ Community services development grants.** The commissioner shall make community services development grants available to communities, providers of older adult services ~~identified in subdivision 1~~, or ~~to~~ a consortium of providers of older adult services~~,~~ to establish older adult services. Grants may be provided for capital and other costs including, but not limited to, start-up and training costs, equipment, and supplies related to older adult services or other residential or service alternatives to nursing facility care. Grants may also be made to renovate current buildings, provide transportation services, fund programs that would allow older adults or individuals with a disability to stay in their own homes by sharing a home, fund programs that coordinate and manage formal and informal services to older adults in their homes to enable them to live as independently as

possible in their own homes as an alternative to nursing home care, or expand state-funded programs in the area.

Subd. 3a. **Priority for other grants.** The commissioner of health shall give priority to a grantee selected under subdivision 3 when awarding technology-related grants, if the grantee is using technology as part of the proposal unless that priority conflicts with existing state or federal guidance related to grant awards by the Department of Health. The commissioner of transportation shall give priority to a grantee under subdivision 3 when distributing transportation-related funds to create transportation options for older adults unless that preference conflicts with existing state or federal guidance related to grant awards by the Department of Transportation.

Subd. 3b. **State waivers.** The commissioner of health may waive applicable state laws and rules for grantees under subdivision 3 on a time-limited basis if the commissioner of health determines that a participating grantee requires a waiver in order to achieve demonstration project goals.

Subd. 3c. **Caregiver support and respite care projects.** (a) The commissioner shall establish projects to expand the availability of caregiver support and respite care services for family and other caregivers. The commissioner shall use a request for proposals to select nonprofit entities to administer the projects. Projects must:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite care services to caregivers of older adults;

(3) assure the health and safety of the older adults;

(4) identify at-risk caregivers;

(5) provide information, education, and training for caregivers in the designated community; and

(6) demonstrate the need in the proposed service area, particularly where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. Preference must be given for projects that reach underserved populations.

(b) Projects must clearly describe:

(1) how they will achieve their purpose;

(2) the process for recruiting, training, and retraining volunteers; and

(3) a plan to promote the project in the designated community, including outreach to persons needing the services.

(c) Money for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) provide information, training, and education to caregivers;

(4) advertise the availability of the caregiver support and respite care project; and

(5) purchase equipment to maintain a system of assigning workers to clients.

(d) Volunteer and caregiver training must include resources on how to support an individual with dementia.

(e) Project money may not be used to supplant existing funding sources.

Subd. 3d. **Core home and community-based services projects.** The commissioner shall select and contract with core home and community-based services providers for projects to provide services and supports to older adults both with and without family and other informal caregivers using a request for proposals process. Projects must:

(1) have a credible public or private nonprofit sponsor providing ongoing financial support;

(2) have a specific, clearly defined geographic service area;

(3) use a practice framework designed to identify high-risk older adults and help them take action to better manage their chronic conditions and maintain their community living;

(4) have a team approach to coordination and care, ensuring that the older adult participants, their families, and the formal and informal providers are all part of planning and providing services;

(5) provide information, support services, homemaking services, counseling, and training for the older adults and family caregivers;

(6) encourage service area or neighborhood residents and local organizations to collaborate in meeting the needs of older adults in their geographic service areas;

(7) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to older adults and their caregivers; and

(8) provide coordination and management of formal and informal services to older adults and their families using less expensive alternatives.

Subd. 3e. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposals process.

Subd. 3f. **Live well at home grants extension.** (a) A community or organization that has previously received a grant under subdivision 3c, 3d, or 3e that funded a project that has proven to be successful and that is no longer eligible for funding under subdivision 3c, 3d, or 3e may apply to the commissioner to receive ongoing funding to sustain the project.

(b) In order to be eligible for a grant under this subdivision, a grant applicant must:

(1) have an operating budget of $300,000 or less;

(2) provide home and community-based services that fill a service gap in a designated geographic area; or

(3) be the only provider of essential community services such as chore services, homemaker services, or transportation in a designated geographic area.

(c) The commissioner shall use a request for proposals process and may use a two-year grant cycle.

Subd. 4. **Eligibility.** Grants may be awarded only to communities and providers or to a consortium of providers that have a local match of 50 percent of the costs for the project in the form of donations, local tax dollars, in-kind donations, fundraising, or other local matches.

Subd. 5. **Grant preference.** The commissioner of human services shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. The commissioner may award grants to the extent grant funds are available and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to $750,000.

Sec. 2. **[256.9756] CAREGIVER RESPITE SERVICES GRANTS.**

Subdivision 1. **Caregiver respite grant program established.** The commissioner of human services must establish a caregiver respite services grant program to increase the availability of respite services for family caregivers of people with dementia and older adults and to provide information, education, and training to respite caregivers and volunteers regarding caring for people with dementia. From the money made available for this purpose,

the commissioner must award grants on a competitive basis to respite service providers, giving priority to areas of the state where there is a high need of respite services.

Subd. 2. **Eligible uses.** Grant recipients awarded grant money under this section must use a portion of the grant award as determined by the commissioner to provide free or subsidized respite services for family caregivers of people with dementia and older adults.

Subd. 3. **Report.** By January 15, 2026, and every other January 15 thereafter, the commissioner shall submit a progress report about the caregiver respite services grants in this section to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over human services. The progress report must include metrics of the use of grant program money.

Sec. 3. Minnesota Statutes 2022, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of

additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; ~~and~~

(9) the person is making timely payments of the assessed monthly fee. A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments~~.~~<u>; and</u>

<u>(10) for a person participating in consumer-directed community supports, the person's monthly service limit must be equal to the monthly service limits in clause (7), except that a person assigned a case mix classification L must receive the monthly service limit for case mix classification A.</u>

(b) The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(c) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(d) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 4. Minnesota Statutes 2022, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **Services covered under alternative care.** Alternative care funding may be used for payment of costs of:

(1) adult day services and adult day services bath;

(2) home care;

(3) homemaker services;

(4) personal care;

(5) case management and conversion case management;

(6) respite care;

(7) specialized supplies and equipment;

(8) home-delivered meals;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) family caregiver training and education;

(15) coaching and counseling;

(16) telehome care to provide services in their own homes in conjunction with in-home visits;

(17) consumer-directed community supports ~~under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~;

(18) environmental accessibility and adaptations; and

(19) discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services for all clients served by a lead agency must not exceed 25 percent of that lead agency's annual alternative care program base allocation, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 5. Minnesota Statutes 2022, section 256B.0917, subdivision 1b, is amended to read:

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

(b) ~~"Community" means a town; township; city; or targeted neighborhood within a city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.~~

~~(c) "Core home and community-based services provider" means a Faith in Action, Living at Home Block Nurse, Congregational Nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.~~

~~(d)~~ "Eldercare development partnership" means a team of representatives of county social service and public health agencies, the area agency on aging, local nursing home providers, local home care providers, and other appropriate home and community-based providers in the area agency's planning and service area.

~~(e)~~ (c) "Long-term services and supports" means any service available under the elderly waiver program or alternative care grant programs, nursing facility services, transportation services, caregiver support and respite care services, and other home and community-based services identified as necessary either to maintain lifestyle choices for older adults or to support them to remain in their own home.

~~(f)~~ (d) "Older adult" refers to an individual who is 65 years of age or older.

Sec. 6. Minnesota Statutes 2022, section 256B.0922, subdivision 1, is amended to read:

Subdivision 1. **Essential community supports.** (a) The purpose of the essential community supports program is to provide targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Essential community supports are available not to exceed ~~$400~~ $600 per person per month. Essential community supports may be used as authorized within an authorization period not to exceed 12 months. Services must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) has received a community assessment under section 256B.0911, subdivisions 17 to 21, 23, 24, or 27, and does not require the level of care provided in a nursing facility;

(4) meets the financial eligibility criteria for the alternative care program under section 256B.0913, subdivision 4;

(5) has an assessment summary; and

(6) has been determined by a community assessment under section 256B.0911, subdivisions 17 to 21, 23, 24, or 27, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) adult day services;

(ii) caregiver support, including respite care;

(iii) homemaker support;

(iv) adult companion services;

~~(iv)~~ (v) chores;

~~(v)~~ (vi) a personal emergency response device or system;

~~(vi)~~ (vii) home-delivered meals; or

~~(vii)~~ (viii) community living assistance as defined by the commissioner.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination, not to exceed $600 in a 12-month authorization period, as part of their assessment summary.

(d) A person who has been determined to be eligible for essential community supports must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for essential community supports.

(e) The commissioner is authorized to use federal matching funds for essential community supports as necessary and to meet demand for essential community supports as outlined in subdivision 2, and that amount of federal funds is appropriated to the commissioner for this purpose.

Sec. 7. Minnesota Statutes 2022, section 256B.434, is amended by adding a subdivision to read:

Subd. 4k. **Property rate increase for certain nursing facilities.** (a) A rate increase under this subdivision ends upon the effective date of the transition of the facility's property rate to a property payment rate under section 256R.26, subdivision 8.

(b) The commissioner shall increase the property rate of a nursing facility located in the city of Saint Paul at 1415 Almond Avenue in Ramsey County by $10.65 on September 1, 2023.

(c) The commissioner shall increase the property rate of a nursing facility located in the city of Duluth at 3111 Church Place in St. Louis County by $20.81 on September 1, 2023.

(d) The commissioner shall increase the property rate of a nursing facility located in the city of Chatfield at 1102 Liberty Street SE in Fillmore County by $21.35 on September 1, 2023.

EFFECTIVE DATE. This section is effective September 1, 2023.

Sec. 8. Minnesota Statutes 2022, section 256M.42, is amended to read:

256M.42 ADULT PROTECTION GRANT ALLOCATIONS.

Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated under this section on an annual basis to each county board ~~and tribal government approved by the commissioner to assume county agency duties~~ for adult ~~protective services or as a lead investigative agency~~ protection under section 626.557 ~~on an annual basis in an amount determined~~ and to Tribal Nations that have voluntarily chosen by resolution of Tribal government to participate in vulnerable adult protection programs according to the following formula after the award of the amounts in paragraph (c):

(1) 25 percent must be allocated to the responsible agency on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner; and

(2) 75 percent must be allocated to the responsible agency on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner.

(b) ~~The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.~~ Notwithstanding this subdivision, no county must be awarded less than a minimum allocation established by the commissioner.

(c) To receive money under this subdivision, a participating Tribal Nation must apply to the commissioner. Of the amount appropriated for purposes of this section, the commissioner must award $100,000 to each federally recognized Tribal Nation with a Tribal resolution establishing a vulnerable adult protection program. Money received by a Tribal Nation under this section must be used for its vulnerable adult protection program.

Subd. 2. **Payment.** The commissioner shall make allocations for the state fiscal year starting July 1, ~~2019~~ 2023, and to each county board or tribal government on or before October 10, ~~2019~~ 2023. The commissioner shall make allocations under subdivision 1 to each county board or tribal government each year thereafter on or before July 10.

Subd. 3. ~~**Prohibition on supplanting existing money**~~ **Purpose of expenditures.** Money received under this section must be used ~~for staffing for protection of vulnerable adults or~~ to meet the agency's duties under section 626.557 and to expand adult protective services to stop, prevent, and reduce risks of maltreatment for adults accepted for services under section 626.557, or for multidisciplinary teams under section 626.5571. ~~Money must not be used to supplant current county or tribe expenditures for these purposes.~~

Subd. 4. **Required expenditures.** State money must be used to expand, not supplant, county or Tribal expenditures for the fiscal year 2023 base for adult protection programs, service interventions, or multidisciplinary teams. This prohibition on county or Tribal expenditures supplanting state money ends July 1, 2027.

Subd. 5. **County performance on adult protection measures.** The commissioner must set vulnerable adult protection measures and standards for money received under this section. The commissioner must require an underperforming county to demonstrate that the county designated money allocated under this section for the purpose required and implemented a reasonable strategy to improve adult protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's money under this section toward the performance improvement plan.

Subd. 6. **American Indian adult protection.** Tribal Nations shall establish vulnerable adult protection measures and standards and report annually to the commissioner on these outcomes and the number of adults served.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 9. Minnesota Statutes 2022, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; Public Employees Retirement Association employer costs; and ~~border city~~ facility-specific rate ~~adjustments~~ modifications under section 256R.481.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 10. Minnesota Statutes 2022, section 256R.17, subdivision 2, is amended to read:

Subd. 2. **Case mix indices.** (a) The commissioner shall assign a case mix index to each case mix classification ~~based on the Centers for Medicare and Medicaid Services staff time measurement study~~ as determined by the commissioner of health under section 144.0724.

(b) An index maximization approach shall be used to classify residents. "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

Sec. 11. Minnesota Statutes 2022, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to (o).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

(h) The portion related to single-bed room incentives is as determined under section 256R.41.

(i) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(j) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(k) The portion related to the Public Employees Retirement Association is the allowable costs divided by the sum of the facility's resident days.

(l) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(m) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(n) The portion related to special dietary needs is the amount determined under section 256R.51.

(o) The portion related to the rate adjustments for ~~border city facilities~~ facility-specific rate modifications is the amount determined under section 256R.481.

(p) The portion related to the rate adjustment for critical access nursing facilities is the amount determined under section 256R.47.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 12. Minnesota Statutes 2022, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) ~~The commissioner shall allow the benefits in clauses (1) to (5)~~ For nursing facilities designated as critical access nursing facilities~~:~~, the commissioner shall allow a supplemental payment above a facility's operating payment rate as determined to be necessary by the commissioner to maintain access to nursing facilities services in isolated areas identified in paragraph (b). The commissioner must approve the amounts of supplemental payments through a memorandum of understanding. Supplemental payments to facilities under this section must be in the form of time-limited rate adjustments included in the external fixed payment rate under section 256R.25.

~~(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;~~

~~(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;~~

~~(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part~~

~~4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;~~

~~(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and~~

~~(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.~~

(d) Designation of a critical access nursing facility is for a maximum period of up to two years, after which the ~~benefits~~ benefit allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

~~(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, 2019.~~

(e) The memorandum of understanding required by paragraph (c) must state that the designation of a critical access nursing facility must be removed if the facility undergoes a change of ownership as defined in section 144A.06, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 13. Minnesota Statutes 2022, section 256R.481, is amended to read:

256R.481 FACILITY-SPECIFIC RATE ~~ADJUSTMENTS FOR BORDER CITY FACILITIES~~ MODIFICATIONS.

Subdivision 1. **Border city facilities.** (a) The commissioner shall allow each nonprofit nursing facility located within the boundaries of the city of Breckenridge or Moorhead prior to January 1, 2015, to apply once annually for a rate add-on to the facility's external fixed costs payment rate.

(b) A facility seeking an add-on to its external fixed costs payment rate under this section must apply annually to the commissioner to receive the add-on. A facility must submit the application within 60 calendar days of the effective date of any add-on under this section. The commissioner may waive the deadlines required by this paragraph under extraordinary circumstances.

(c) The commissioner shall provide the add-on to each eligible facility that applies by the application deadline.

(d) The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities

located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1 as determined under section 256R.22, subdivision 4.

Subd. 2. **Nursing facility in Chisholm; temporary rate add-on.** Effective July 1, 2023, through December 31, 2027, the commissioner shall provide an external fixed rate add-on for the nursing facility in the city of Chisholm in the amount of $11.81. If this nursing facility completes a moratorium exception project that is approved after March 27, 2023, this subdivision expires the day before the effective date of that moratorium rate adjustment or December 31, 2027, whichever is earlier. The commissioner of human services shall notify the revisor of statutes if this subdivision expires prior to December 31, 2027.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 14. Minnesota Statutes 2022, section 256R.53, is amended by adding a subdivision to read:

Subd. 3. **Nursing facility in Fergus Falls.** Notwithstanding sections 256B.431, 256B.434, and 256R.26, subdivision 9, a nursing facility located in the city of Fergus Falls licensed for 105 beds on September 1, 2021, must have the property portion of its total payment rate determined according to sections 256R.26 to 256R.267.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 15. Minnesota Statutes 2022, section 256R.53, is amended by adding a subdivision to read:

Subd. 4. **Nursing facility in Red Wing.** The operating payment rate for a facility located in the city of Red Wing at 1412 West 4th Street is the sum of its direct care costs per standardized day, its other care-related costs per resident day, and its other operating costs per day.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 16. Minnesota Statutes 2022, section 256S.15, subdivision 2, is amended to read:

Subd. 2. **Foster care limit.** The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the monthly case mix budget cap for the participant as

specified in sections 256S.18, subdivision 3, and 256S.19, ~~subdivisions~~ subdivision 3 ~~and~~ ~~4~~.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 17. Minnesota Statutes 2022, section 256S.18, is amended by adding a subdivision to read:

Subd. 3a. **Monthly case mix budget caps for consumer-directed community supports.** The monthly case mix budget caps for each case mix classification for consumer-directed community supports must be equal to the monthly case mix budget caps in subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 18. Minnesota Statutes 2022, section 256S.19, subdivision 3, is amended to read:

Subd. 3. **Calculation of monthly conversion budget ~~cap without consumer-directed community supports~~ caps.** (a) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports~~ must be based on the nursing facility case mix adjusted total payment rate of the nursing facility where the elderly waiver applicant currently resides for the applicant's case mix classification as determined according to section 256R.17.

(b) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports shall~~ must be calculated by multiplying the applicable nursing facility case mix adjusted total payment rate by 365, dividing by 12, and subtracting the participant's maintenance needs allowance.

(c) A participant's initially approved monthly conversion budget cap for elderly waiver services ~~without consumer-directed community supports shall~~ must be adjusted at least annually as described in section 256S.18, subdivision 5.

(d) Conversion budget caps for individuals participating in consumer-directed community supports must be set as described in paragraphs (a) to (c).

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 19. Minnesota Statutes 2022, section 256S.203, subdivision 1, is amended to read:

Subdivision 1. **Capitation payments.** The commissioner must adjust the elderly waiver capitation payment rates for managed care organizations paid to reflect the monthly service rate limits for customized living services and 24-hour customized living services established

under section 256S.202 ~~and~~, the rate adjustments for disproportionate share facilities under section 256S.205, and the assisted living facility closure payments under section 256S.206.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256S.203, subdivision 2, is amended to read:

Subd. 2. **Reimbursement rates.** Medical assistance rates paid to customized living providers by managed care organizations under this chapter must not exceed the monthly service rate limits and component rates as determined by the commissioner under sections 256S.15 and 256S.20 to 256S.202, plus any rate adjustment or special payment under section 256S.205 or 256S.206.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2022, section 256S.205, subdivision 3, is amended to read:

Subd. 3. **Rate adjustment eligibility criteria.** Only facilities satisfying all of the following conditions on September 1 of the application year are eligible for designation as a disproportionate share facility:

(1) at least ~~83.5~~ 80 percent of the residents of the facility are customized living residents; and

(2) at least ~~70~~ 50 percent of the customized living residents are elderly waiver participants.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2022, section 256S.205, subdivision 5, is amended to read:

Subd. 5. **Rate adjustment; rate floor.** (a) Notwithstanding the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner must establish a rate floor equal to ~~$119~~ $139 per resident per day for 24-hour customized living services provided to an elderly waiver participant in a designated disproportionate share facility.

(b) The commissioner must apply the rate floor to the services described in paragraph (a) provided during the rate year.

(c) The commissioner must adjust the rate floor by the same amount and at the same time as any adjustment to the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2.

(d) The commissioner shall not implement the rate floor under this section if the customized living rates established under sections 256S.21 to 256S.215 will be implemented at 100 percent on January 1 of the year following an application year.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. **[256S.206] ASSISTED LIVING FACILITY CLOSURE PAYMENTS.**

Subdivision 1. **Assisted living facility closure payments provided.** The commissioner of human services shall establish a special payment program to support licensed assisted living facilities who serve waiver participants under section 256B.49 and chapter 256S when the assisted living facility is acting to close the facility as outlined in section 144G.57. The payments must support the facility to meet the health and safety needs of residents during facility occupancy and revenue decline.

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

(b) "Closure period" means the number of days in the approved closure plan for the eligible facility as determined by the commissioner of health under section 144G.57, not to exceed 60 calendar days.

(c) "Eligible claim" means a claim for customized living services and 24-hour customized living services provided to waiver participants under section 256B.49 and chapter 256S during the eligible facility's closure period.

(d) "Eligible facility" means a licensed assisted living facility that has an approved closure plan, as determined by the commissioner of health under section 144G.57, that is acting to close the facility and no longer serve residents in that setting. A facility where a provider is relinquishing an assisted living facility license to transition to a different license type is not an eligible facility.

Subd. 3. **Application.** (a) An eligible facility may apply to the commissioner of human services for assisted living closure transition payments in the manner prescribed by the commissioner.

(b) The commissioner shall notify the facility within 14 calendars days of the facility's application about the result of the application, including whether the facility meets the definition of an eligible facility.

Subd. 4. **Issuing closure payments.** (a) The commissioner must increase the payment for eligible claims by 50 percent during the eligible facility's closure period.

(b) The commissioner must direct managed care organizations to increase the payment for eligible claims by 50 percent during the eligible facility's closure period for eligible claims submitted to managed care organizations.

Subd. 5. **Interagency coordination.** The commissioner of human services must coordinate the activities under this section with any impacted state agencies and lead agencies.

EFFECTIVE DATE. This section is effective July 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 24. Minnesota Statutes 2022, section 256S.21, is amended to read:

256S.21 RATE SETTING; APPLICATION; EVALUATION.

Subdivision 1. **Application of rate setting.** The ~~payment~~ rate methodologies in sections 256S.2101 to 256S.215 apply to:

(1) elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter;

(2) alternative care under section 256B.0913;

(3) essential community supports under section 256B.0922; and

(4) community access for disability inclusion customized living and brain injury customized living under section 256B.49.

Subd. 2. **Evaluation of rate setting.** (a) Beginning January 1, 2024, and every two years thereafter, the commissioner, in consultation with stakeholders, shall use all available data and resources to evaluate the following rate setting elements:

(1) the base wage index;

(2) the factors and supervision wage components; and

(3) the formulas to calculate adjusted base wages and rates.

(b) Beginning January 15, 2026, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services finance and policy with a full report on the information and data gathered under paragraph (a).

Subd. 3. **Cost reporting.** (a) As determined by the commissioner, in consultation with stakeholders, a provider enrolled to provide services with rates determined under this chapter must submit requested cost data to the commissioner to support evaluation of the rate methodologies in this chapter. Requested cost data may include but are not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

(c) The commissioner shall coordinate the cost reporting activities required under this section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders, may submit recommendations on rate methodologies in this chapter, including ways to monitor and enforce the spending requirements directed in section 256S.2101, subdivision 3, through the reports directed by subdivision 2.

EFFECTIVE DATE. Subdivisions 1 and 2 are effective January 1, 2024. Subdivision 3 is effective January 1, 2025.

Sec. 25. Minnesota Statutes 2022, section 256S.2101, subdivision 2, is amended to read:

Subd. 2. **Phase-in for elderly waiver rates.** Except for home-delivered meals ~~as described in section 256S.215, subdivision 15~~ and the services in subdivision 2a, all rates and rate components for elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter; alternative care under section 256B.0913; and essential community supports under section 256B.0922 shall be:

(1) beginning January 1, 2024, the sum of ~~18.8~~ 27.8 percent of the rates calculated under sections 256S.211 to 256S.215, and ~~81.2~~ 72.2 percent of the rates calculated using the rate methodology in effect as of June 30, 2017~~. The rate for home-delivered meals shall be the sum of the service rate in effect as of January 1, 2019, and the increases described in section 256S.215, subdivision 15~~; and

(2) beginning January 1, 2026, the sum of 25 percent of the rates calculated under sections 256S.211 to 256S.215, and 75 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Sec. 26. Minnesota Statutes 2022, section 256S.2101, is amended by adding a subdivision to read:

Subd. 2a. **Service rates exempt from phase-in.** Subdivision 2 does not apply to rates for homemaker services described in section 256S.215, subdivisions 9 to 11.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 27. Minnesota Statutes 2022, section 256S.2101, is amended by adding a subdivision to read:

Subd. 3. **Spending requirements.** (a) Except for community access for disability inclusion customized living and brain injury customized living under section 256B.49, at

least 80 percent of the marginal increase in revenue from the implementation of any adjustments to the phase-in in subdivision 2, or any updates to services rates directed under section 256S.211, subdivision 3, must be used to increase compensation-related costs for employees directly employed by the provider.

(b) For the purposes of this subdivision, compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's paid share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to the implementation of the adjusted phase-in in subdivision 2, including any concurrent or subsequent adjustments to the base wage indices.

(c) Compensation-related costs for persons employed in the central office of a corporation or entity that has an ownership interest in the provider or exercises control over the provider, or for persons paid by the provider under a management contract, do not count toward the 80 percent requirement under this subdivision.

(d) A provider agency or individual provider that receives additional revenue subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of the new phase-in proportion or adjustment to the base wage indices subject to the requirements of this subdivision, the provider must post the distribution plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee has not received the compensation-related increase described in the plan.

Sec. 28. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision to read:

Subd. 3. **Updating services rates.** On January 1, 2024, and every two years thereafter, the commissioner shall recalculate rates for services as directed in section 256S.215. Prior to recalculating the rates, the commissioner shall:

(1) update the base wage index for services in section 256S.212 based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data;

(2) update the payroll taxes and benefits factor in section 256S.213, subdivision 1, based on the most recently available nursing facility cost report data;

(3) update the supervision wage components in section 256S.213, subdivisions 4 and 5, based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data; and

(4) update the adjusted base wage for services as directed in section 256S.214.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 29. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision to read:

Subd. 4. **Updating home-delivered meals rate.** On January 1 of each year, the commissioner shall update the home-delivered meals rate in section 256S.215, subdivision 15, by the percent increase in the nursing facility dietary per diem using the two most recently available nursing facility cost reports.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 30. Minnesota Statutes 2022, section 256S.212, is amended to read:

256S.212 RATE SETTING; BASE WAGE INDEX.

Subdivision 1. **Updating SOC codes.** If any of the SOC codes and positions used in this section are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Subd. 2. **Home management and support services base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI

MetroSA average wage for home health and personal ~~and home~~ care aide (SOC code ~~39-9021~~ 31-1120); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 3. **Home care aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home care aide base wage equals ~~50~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code ~~31-1011~~ 31-1120); and ~~50~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 4. **Home health aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home health aide base wage equals ~~20~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); ~~and 80~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120).

Subd. 5. **Medication setups by licensed nurse base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the medication setups by licensed nurse base wage equals ~~ten~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and ~~90~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 6. **Chore services base wage.** The chore services base wage equals ~~100~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 7. **Companion services base wage.** The companion services base wage equals ~~50~~ 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care aides (SOC code ~~39-9021~~ 31-1120); and ~~50~~

20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 8. **Homemaker ~~services and~~ assistance with personal care base wage.** The homemaker ~~services and~~ assistance with personal care base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 9. **Homemaker ~~services and~~ cleaning base wage.** The homemaker ~~services and~~ cleaning base wage equals ~~60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20~~ 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 10. **Homemaker ~~services and~~ home management base wage.** The homemaker ~~services and~~ home management base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 11. **In-home respite care services base wage.** The in-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 12. **Out-of-home respite care services base wage.** The out-of-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of

the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 13. **Individual community living support base wage.** The individual community living support base wage equals ~~20~~ 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~licensed practical and licensed vocational nurses~~ social and human services assistants (SOC code ~~29-2061~~ 21-1093); and ~~80~~ 40 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 14. **Registered nurse base wage.** The registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 15. ~~**Social worker**~~ **Unlicensed supervisor base wage.** The ~~social worker~~ unlicensed supervisor base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~medical and public health social~~ first-line supervisors of personal service workers (SOC code ~~21-1022~~ 39-1022).

Subd. 16. **Adult day services base wage.** The adult day services base wage equals 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120); and 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1131).

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 31. Minnesota Statutes 2022, section 256S.213, is amended to read:

256S.213 RATE SETTING; FACTORS.

Subdivision 1. **Payroll taxes and benefits factor.** The payroll taxes and benefits factor is the sum of net payroll taxes and benefits, divided by the sum of all salaries for all nursing facilities on the most recent and available cost report.

Subd. 2. **General and administrative factor.** The general and administrative factor is ~~the difference of net general and administrative expenses and administrative salaries, divided by total operating expenses for all nursing facilities on the most recent and available cost report~~ 14.4 percent.

Subd. 3. **Program plan support factor.** (a) The program plan support factor is ~~12.8~~ ten percent for the following services to cover the cost of direct service staff needed to provide

support for ~~home and community-based~~ the service when not engaged in direct contact with participants~~.~~:

(1) adult day services;

(2) customized living; and

(3) foster care.

(b) The program plan support factor is 15.5 percent for the following services to cover the cost of direct service staff needed to provide support for the service when not engaged in direct contact with participants:

(1) chore services;

(2) companion services;

(3) homemaker assistance with personal care;

(4) homemaker cleaning;

(5) homemaker home management;

(6) in-home respite care;

(7) individual community living support; and

(8) out-of-home respite care.

Subd. 4. **Registered nurse management and supervision ~~factor~~ wage component.** The registered nurse management and supervision ~~factor~~ wage component equals 15 percent of the registered nurse adjusted base wage as defined in section 256S.214.

Subd. 5. ~~**Social worker**~~ **Unlicensed supervisor supervision ~~factor~~ wage component.** The ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component equals 15 percent of the ~~social worker~~ unlicensed supervisor adjusted base wage as defined in section 256S.214.

Subd. 6. **Facility and equipment factor.** The facility and equipment factor for adult day services is 16.2 percent.

Subd. 7. **Food, supplies, and transportation factor.** The food, supplies, and transportation factor for adult day services is 24 percent.

Subd. 8. **Supplies and transportation factor.** The supplies and transportation factor for the following services is 1.56 percent:

(1) chore services;

(2) companion services;

(3) homemaker assistance with personal care;

(4) homemaker cleaning;

(5) homemaker home management;

(6) in-home respite care;

(7) individual community support services; and

(8) out-of-home respite care.

Subd. 9. **Absence factor.** The absence factor for the following services is 4.5 percent:

(1) adult day services;

(2) chore services;

(3) companion services;

(4) homemaker assistance with personal care;

(5) homemaker cleaning;

(6) homemaker home management;

(7) in-home respite care;

(8) individual community living support; and

(9) out-of-home respite care.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 32. Minnesota Statutes 2022, section 256S.214, is amended to read:

256S.214 RATE SETTING; ADJUSTED BASE WAGE.

For the purposes of section 256S.215, the adjusted base wage for each position equals the position's base wage under section 256S.212 plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor under section 256S.213, subdivision 1;

~~(2) the position's base wage multiplied by the general and administrative factor under section 256S.213, subdivision 2; and~~

~~(3)~~ (2) the position's base wage multiplied by the applicable program plan support factor under section 256S.213, subdivision 3~~.~~; and

(3) the position's base wage multiplied by the absence factor under section 256S.213, subdivision 9, if applicable.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 33. Minnesota Statutes 2022, section 256S.215, subdivision 2, is amended to read:

Subd. 2. **Home management and support services component rate.** The component rate for home management and support services is calculated as follows:

(1) sum the home management and support services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

Sec. 34. Minnesota Statutes 2022, section 256S.215, subdivision 3, is amended to read:

Subd. 3. **Home care aide services component rate.** The component rate for home care aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 35. Minnesota Statutes 2022, section 256S.215, subdivision 4, is amended to read:

Subd. 4. **Home health aide services component rate.** The component rate for home health aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 36. Minnesota Statutes 2022, section 256S.215, subdivision 7, is amended to read:

Subd. 7. **Chore services rate.** The 15-minute unit rate for chore services is calculated as follows:

(1) sum the chore services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 37. Minnesota Statutes 2022, section 256S.215, subdivision 8, is amended to read:

Subd. 8. **Companion services rate.** The 15-minute unit rate for companion services is calculated as follows:

(1) sum the companion services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 38. Minnesota Statutes 2022, section 256S.215, subdivision 9, is amended to read:

Subd. 9. **Homemaker ~~services and~~ assistance with personal care rate.** The 15-minute unit rate for homemaker ~~services and~~ assistance with personal care is calculated as follows:

(1) sum the homemaker ~~services and~~ assistance with personal care adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 39. Minnesota Statutes 2022, section 256S.215, subdivision 10, is amended to read:

Subd. 10. **Homemaker ~~services and~~ cleaning rate.** The 15-minute unit rate for homemaker ~~services and~~ cleaning is calculated as follows:

(1) sum the homemaker ~~services and~~ cleaning adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 40. Minnesota Statutes 2022, section 256S.215, subdivision 11, is amended to read:

Subd. 11. **Homemaker ~~services and~~ home management rate.** The 15-minute unit rate for homemaker ~~services and~~ home management is calculated as follows:

(1) sum the homemaker ~~services and~~ home management adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 41. Minnesota Statutes 2022, section 256S.215, subdivision 12, is amended to read:

Subd. 12. **In-home respite care services rates.** (a) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the in-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 42. Minnesota Statutes 2022, section 256S.215, subdivision 13, is amended to read:

Subd. 13. **Out-of-home respite care services rates.** (a) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The out-of-home respite care services daily rate equals the 15-minute unit rate for out-of-home respite care services multiplied by 18.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 43. Minnesota Statutes 2022, section 256S.215, subdivision 14, is amended to read:

Subd. 14. **Individual community living support rate.** The individual community living support rate is calculated as follows:

(1) sum the ~~home care aide~~ individual community living support adjusted base wage and the ~~social worker~~ registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 44. Minnesota Statutes 2022, section 256S.215, subdivision 15, is amended to read:

Subd. 15. **Home-delivered meals rate.** Effective January 1, 2024, the home-delivered meals rate ~~equals $9.30~~ is $8.17, updated as directed in section 256S.211, subdivision 4. ~~The commissioner shall increase the home delivered meals rate every July 1 by the percent~~

~~increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.~~

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 45. Minnesota Statutes 2022, section 256S.215, subdivision 16, is amended to read:

Subd. 16. **Adult day services rate.** The 15-minute unit rate for adult day services~~, with an assumed staffing ratio of one staff person to four participants, is the sum of~~ is calculated as follows:

(1) ~~one-sixteenth of the home care aide~~ divide the adult day services adjusted base wage~~, except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ by five to reflect an assumed staffing ratio of one to five;

(2) ~~one-fourth of the registered nurse management and supervision factor~~ sum the result of clause (1) and the registered nurse management and supervision wage component; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (2) by the general and administrative factor;

(4) multiply the result of clause (2) by the facility and equipment factor;

(5) multiply the result of clause (2) by the food, supplies, and transportation factor; and

(6) sum the results of clauses (2) to (5) and divide the result by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 46. Minnesota Statutes 2022, section 256S.215, subdivision 17, is amended to read:

Subd. 17. **Adult day services bath rate.** The 15-minute unit rate for adult day services bath is ~~the sum of~~ calculated as follows:

(1) ~~one-fourth of the home care aide~~ sum the adult day services adjusted base wage~~, except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ and the nurse management and supervision wage component;

(2) ~~one-fourth of the registered nurse management and supervision~~ multiply the result of clause (1) by the general and administrative factor; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (1) by the facility and equipment factor;

(4) multiply the result of clause (1) by the food, supplies, and transportation factor; and

(5) sum the results of clauses (1) to (4) and divide the result by four.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 47. **DIRECTION TO COMMISSIONER; FUTURE PACE IMPLEMENTATION FUNDING.**

The commissioner of human services must work with stakeholders to develop recommendations for financing mechanisms to complete the actuarial work and cover the administrative costs of a program of all-inclusive care for the elderly (PACE). The commissioner must recommend a financing mechanism that could begin July 1, 2025. By December 15, 2023, the commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance on the commissioner's progress toward developing a recommended financing mechanism.

Sec. 48. **DIRECTION TO COMMISSIONER; CAREGIVER RESPITE SERVICES GRANTS.**

Beginning in fiscal year 2025, the commissioner of human services must continue the respite services for older adults grant program established under Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3, under the authority granted under Minnesota Statutes, section 256.9756. The commissioner may begin the grant application process for awarding grants under Minnesota Statutes, section 256.9756, during fiscal year 2024 in order to facilitate the continuity of the grant program during the transition from a temporary program to a permanent one.

Sec. 49. **NURSING FACILITY FUNDING.**

(a) Effective July 1, 2023, through June 30, 2025, the total payment rate for all facilities reimbursed under Minnesota Statutes, chapter 256R, must be increased by an amount per resident day equal to a net state general fund expenditure of $37,045,000 in fiscal year 2024 and $37,045,000 in fiscal year 2025. Effective July 1, 2025, the total payment rate for all facilities reimbursed under Minnesota Statutes, chapter 256R, must be increased by an amount per resident day equal to a net state expenditure of $23,698,000 per fiscal year. The rate increases under this paragraph are add-ons to the facilities' rates calculated under Minnesota Statutes, chapter 256R.

(b) To be eligible to receive a payment under this section, a nursing facility must attest to the commissioner of human services that the additional revenue will be used exclusively

to increase compensation-related costs for employees directly employed by the facility on or after July 1, 2023, excluding:

(1) owners of the building and operation;

(2) persons employed in the central office of an entity that has any ownership interest in the nursing facility or exercises control over the nursing facility;

(3) persons paid by the nursing facility under a management contract; and

(4) persons providing separately billable services.

(c) Contracted housekeeping, dietary, and laundry employees providing services on site at the nursing facility are eligible for compensation-related cost increases under this section, provided the agency that employs them submits to the nursing facility proof of the costs of the increases provided to those employees.

(d) For purposes of this section, compensation-related costs include:

(1) permanent new increases to wages and salaries implemented on or after July 1, 2023, and before September 1, 2023, for nursing facility employees;

(2) permanent new increases to wages and salaries implemented on or after July 1, 2023, and before September 1, 2023, for employees in the organization's shared services departments of hospital-attached nursing facilities for the nursing facility allocated share of wages; and

(3) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, PERA, workers' compensation, and pension and employee retirement accounts directly associated with the wage and salary increases in clauses (1) and (2) incurred no later than December 31, 2025, and paid for no later than June 30, 2026.

(e) A facility that receives a rate increase under this section must complete a distribution plan in the form and manner determined by the commissioner. This plan must specify the total amount of money the facility is estimated to receive from this rate increase and how that money will be distributed to increase the allowable compensation-related costs described in paragraph (d) for employees described in paragraphs (b) and (c). This estimate must be computed by multiplying $28.65 by the sum of the medical assistance and private pay resident days as defined in Minnesota Statutes, section 256R.02, subdivision 45, for the period beginning October 1, 2021, through September 30, 2022, dividing this sum by 365 and multiplying the result by 915. A facility must submit its distribution plan to the commissioner by October 1, 2023. The commissioner may review the distribution plan to ensure that the payment rate adjustment per resident day is used in accordance with this

section. The commissioner may allow for a distribution plan amendment under exceptional circumstances to be determined at the sole discretion of the commissioner.

(f) By September 1, 2023, a facility must post the distribution plan summary and leave it posted for a period of at least six months in an area of the facility to which all employees have access. The posted distribution plan summary must be in the form and manner determined by the commissioner. The distribution plan summary must include instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee believes the employee is covered by paragraph (b) or (c) and has not received the compensation-related increases described in paragraph (d). The instruction to such employees must include the e-mail address and telephone number that may be used by the employee to contact the commissioner's representative. The posted distribution plan summary must demonstrate how the increase in paragraph (a) received by the nursing facility from July 1, 2023, through December 1, 2025, will be used in full to pay the compensation-related costs in paragraph (d) for employees described in paragraphs (b) and (c).

(g) If the nursing facility expends less on new compensation-related costs than the amount that was made available by the rate increase in this section for that purpose, the amount of this rate adjustment must be reduced to equal the amount utilized by the facility for purposes authorized under this section. If the facility fails to post the distribution plan summary in its facility as required, fails to submit its distribution plan to the commissioner by the due date, or uses the money for unauthorized purposes, these rate increases must be treated as an overpayment and subsequently recovered.

(h) The commissioner shall not treat payments received under this section as an applicable credit for purposes of setting total payment rates under Minnesota Statutes, chapter 256R.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 50. **INCREASED MEDICAL ASSISTANCE INCOME LIMIT FOR OLDER ADULTS AND PERSONS WITH DISABILITIES.**

Effective July 1, 2023, the commissioner of human services must increase the income limit under Minnesota Statutes, section 256B.056, subdivision 4, paragraph (a), to a level that is projected to result in a net cost to the state of $5,000,000 for the 2026-2027 biennium.

Sec. 51. **RETURN FORECASTED FUNDS TO NURSING FACILITIES.**

(a) The commissioner shall use the estimated total annual payments for nursing facilities from the Department of Human Services February 2023 forecast for fiscal years 2023, 2024, 2025, 2026, and 2027 for the rate add-ons as directed in paragraphs (b) to (f). The add-ons described below are only implemented when they result in an increase.

(b) For the year beginning January 1, 2024, the commissioner shall determine the amount of unspent forecast funds by subtracting the actual total annual state, federal, and county payments for fiscal year 2023 from the amount specified in paragraph (a) for 2023. The amount shall be converted into an equal per resident day increase and applied as an add-on to all nursing facilities' rates.

(c) For the year beginning January 1, 2025, the commissioner shall determine the amount of unspent forecast funds by subtracting the actual total annual state, federal, and county payments for fiscal year 2024 from the amount specified in paragraph (a) for 2024. The amount shall be converted into an equal per resident day increase and applied as an add-on to all nursing facilities' rates.

(d) For the year beginning January 1, 2026, the commissioner shall determine the amount of unspent forecast funds by subtracting the actual total annual state, federal, and county payments for fiscal year 2025 from the amount specified in paragraph (a) for 2025. The amount shall be converted into an equal per resident day increase and applied as an add-on to all nursing facilities' rates.

(e) For the year beginning January 1, 2027, the commissioner shall determine the amount of unspent forecast funds by subtracting the actual total annual state, federal, and county payments for fiscal year 2026 from the amount specified in paragraph (a) for 2026. The amount shall be converted into an equal per resident day increase and applied as an add-on to all nursing facilities' rates.

(f) For the year beginning January 1, 2028, the commissioner shall determine the amount of unspent forecast funds by subtracting the actual total annual state, federal, and county payments for fiscal year 2027 from the amount specified in paragraph (a) for 2027. The amount shall be converted into an equal per resident day increase and applied as an add-on to all nursing facilities' rates.

Sec. 52. **SENIOR HOUSING-RELATED STRESS AND MENTAL HEALTH PREVENTION.**

(a) In order to prevent inordinate mental health stress and financial distress for seniors and persons with disabilities, effective for any lease agreement entered into on or after July 1, 2023, any properties owned by a corporation founded in 1992; domiciled in Minnesota, with over 38,000 properties in 19 states as of January 1, 2023; and leasing properties in Coon Rapids, Blaine, Champlin, and elsewhere in Minnesota must not increase rents by over three percent per year for any resident.

(b) Any rent increases for residents of a property described in paragraph (a) exceeding three percent per year effective on or after January 1, 2022, must be credited by the corporation described in paragraph (a) to the affected lessees.

(c) Any fees charged to residents of a property described in paragraph (a) for repairs occurring on or after July 1, 2023, must not exceed actual costs.

(d) Beginning July 1, 2023, all residents of a property described in paragraph (a) must be permitted to park one resident-owned vehicle per unit in an indoor garage at no cost.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2022.

Sec. 53. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the headnote in Minnesota Statutes, section 256B.0917, from "HOME AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS" to "ELDERCARE DEVELOPMENT PARTNERSHIPS."

Sec. 54. **REPEALER.**

(a) Minnesota Statutes 2022, section 256B.0917, subdivisions 1a, 6, 7a, and 13, are repealed.

(b) Minnesota Statutes 2022, section 256S.19, subdivision 4, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective July 1, 2023. Paragraph (b) is effective January 1, 2024.

ARTICLE 3
HEALTH CARE

Section 1. Minnesota Statutes 2022, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, not including a child determined eligible for medical assistance without consideration of parental income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or a child accessing home and community-based waiver services, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 275 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 1.65 percent of adjusted gross income at 275 percent of federal poverty guidelines and increases to 4.5 percent of adjusted gross income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

(2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 4.5 percent of adjusted gross income;

(3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 4.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 5.99 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution shall be 7.49 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered

child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including~~,~~ but not limited to~~,~~ the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

Sec. 2. Minnesota Statutes 2022, section 256B.04, is amended by adding a subdivision to read:

Subd. 26. **Notice of employed persons with disabilities program.** At the time of initial enrollment and at least annually thereafter, the commissioner shall provide information on the medical assistance program for employed persons with disabilities under section 256B.057, subdivision 9, to all medical assistance enrollees who indicate they have a disability.

Sec. 3. Minnesota Statutes 2022, section 256B.056, subdivision 3, is amended to read:

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

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

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

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

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

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

as an employed person with a disability~~, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d)~~;

(6) a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person ~~and the person's spouse~~ in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded liquid assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. ~~The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ Persons eligible under this clause are not subject to the provisions in section 256B.059; and

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

(b) No asset limit shall apply to persons eligible under ~~section~~ sections 256B.055, subdivision 15, and 256B.057, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who~~:~~

~~(1)~~ but for excess earnings or assets~~,~~ meets the definition of disabled under the Supplemental Security Income program~~;~~

~~(2) meets the asset limits in paragraph (d); and~~

~~(3) pays a premium and other obligations under paragraph (e)~~.

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income ~~or assets~~ shall be disregarded for purposes of eligibility ~~and premium determinations~~.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met ~~and the enrollee must pay all calculated premium costs for continued eligibility~~.

~~(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:~~

~~(1) all assets excluded under section 256B.056;~~

~~(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;~~

~~(3) medical expense accounts set up through the person's employer; and~~

~~(4) spousal assets, including spouse's share of jointly held assets.~~

~~(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).~~

~~(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income~~

~~at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.~~

~~(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.~~

~~(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).~~

~~(4)~~ (d) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

~~(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.~~

~~(f)~~ (e) A person's eligibility ~~and premium~~ shall be determined by the local county agency. ~~Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.~~

~~(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported.~~ (f) Enrollees must report any change in income or household size within ten days of when the change occurs. ~~A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.~~

~~(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.~~

~~(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled.~~

~~Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.~~

~~(j)~~ (g) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

(h) For enrollees ~~whose income does not exceed 200 percent of the federal poverty guidelines~~ who are: (1) eligible under this subdivision and ~~who are~~ also enrolled in Medicare~~,~~; and (2) not eligible for medical assistance reimbursement of Medicare premiums under subdivisions 3, 3a, 3b, or 4, the commissioner shall reimburse the enrollee for Medicare part A and Medicare part B premiums ~~under section 256B.0625, subdivision 15, paragraph (a).~~ and part A and part B coinsurance and deductibles. Reimbursement of the Medicare coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person was receiving benefits as a qualified Medicare beneficiary.

(i) The commissioner must permit any individual who was disenrolled for nonpayment of premiums previously required under this subdivision to reapply for medical assistance under this subdivision and be reenrolled if eligible without paying past due premiums.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (h).

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

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

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

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

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

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

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

(1) adhere to the policies defined by the commissioner;

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

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

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

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

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

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

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

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

(i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

(k) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

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

(3) investigate all complaints and appeals.

(l) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care,

local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

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

(1) $0.22 per mile for client reimbursement;

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

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and ~~$11~~ $12.93 for the base rate and ~~$1.30~~ $1.53 per mile when provided by a nonemergency medical transportation provider;

(4) ~~$13~~ $15.28 for the base rate and ~~$1.30~~ $1.53 per mile for assisted transport;

(5) ~~$18~~ $21.15 for the base rate and ~~$1.55~~ $1.82 per mile for lift-equipped/ramp transport;

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

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

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

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

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

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

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

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

(r) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 6. Minnesota Statutes 2022, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one

percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

EFFECTIVE DATE. This section is effective July 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 7. Minnesota Statutes 2022, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision to read:

Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is for recipients age 21 or under who elect to receive hospice care delivered in a facility that is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility under section 144A.75, subdivision 13, paragraph (a). Hospice care services under subdivision 22 are not hospice respite or end-of-life care under this subdivision.

(b) The payment rates for coverage under this subdivision must be 100 percent of the Medicare rate for continuous home care hospice services as published in the Centers for Medicare and Medicaid Services annual final rule updating payments and policies for hospice care. Payment for hospice respite and end-of-life care under this subdivision must be made from state money, though the commissioner must seek to obtain federal financial participation for the payments. Payment for hospice respite and end-of-life care must be paid to the residential hospice facility and are not included in any limit or cap amount applicable to hospice services payments to the elected hospice services provider.

(c) Certification of the residential hospice facility by the federal Medicare program must not be a requirement of medical assistance payment for hospice respite and end-of-life care under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 256B.073, subdivision 3, is amended to read:

Subd. 3. **Requirements.** (a) In developing implementation requirements for electronic visit verification, the commissioner shall ensure that the requirements:

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

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

(3) consider existing best practices and use of electronic visit verification;

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

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

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

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

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

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

(e) The commissioner shall make available and publish on the agency website the name and contact information for the vendor of the state-selected electronic visit verification system and the other vendors that offer alternative electronic visit verification systems. The information provided must state that the state-selected electronic visit verification system is offered at no cost to the provider of services and that the provider may choose an alternative system that may be at a cost to the provider.

Sec. 10. Minnesota Statutes 2022, section 256B.073, is amended by adding a subdivision to read:

Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system selected by the commissioner and the vendor's affiliate must comply with the requirements of this subdivision.

(b) The vendor of the state-selected electronic visit verification system and the vendor's affiliate must:

(1) notify the provider of services that the provider may choose the state-selected electronic visit verification system at no cost to the provider;

(2) offer the state-selected electronic visit verification system to the provider of services prior to offering any fee-based electronic visit verification system;

(3) notify the provider of services that the provider may choose any fee-based electronic visit verification system prior to offering the vendor's or its affiliate's fee-based electronic visit verification system;

(4) when offering the state-selected electronic visit verification system, clearly differentiate between the state-selected electronic visit verification system and the vendor's or its affiliate's alternative fee-based system; and

(5) allow the provider of services, at no cost to the provider, to terminate the agreement after 12 months of the provider executing the agreement.

(c) The vendor of the state-selected electronic visit verification system and the vendor's affiliate must not use state data that is not available to other vendors of electronic visit verification systems to develop, promote, or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the state-selected electronic visit verification system must provide proof of compliance with the requirements of this subdivision.

(e) An agreement between the vendor of the state-selected electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the state-selected system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 11. Minnesota Statutes 2022, section 256B.14, subdivision 2, is amended to read:

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules ~~shall be consistent with the requirements of section 252.27 for~~ do not apply to parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or to parents of children accessing home and community-based waiver services. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

Sec. 12. Minnesota Statutes 2022, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic

care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, and anesthesia services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) Effective for services provided on or after September 1, 2014, payments for ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory services, public health nursing services, eyeglasses not subject to a volume purchase contract, and hearing aids not subject to a volume purchase contract shall be increased by three percent and payments for outpatient hospital facility fees shall be increased by three percent. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(f) Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable medical equipment not subject to a volume purchase contract, and prosthetics and orthotics, provided on or after July 1, 2015, shall be increased by three percent from the rates as determined under paragraphs (i) and (j).

(g) Effective for services provided on or after July 1, 2015, payments for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified

in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(i) Effective for services provided on or after July 1, 2015, the following categories of medical supplies and durable medical equipment shall be individually priced items: ~~enteral nutrition and supplies,~~ customized and other specialized tracheostomy tubes and supplies, electric patient lifts, and durable medical equipment repair and service. This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, and items provided to dually eligible recipients when Medicare is the primary payer for the item. The commissioner shall not apply any medical assistance rate reductions to durable medical equipment as a result of Medicare competitive bidding.

(j) Effective for services provided on or after July 1, 2015, medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased as follows:

(1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare competitive bid that took effect in January of 2009 shall be increased by 9.5 percent; and

(2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the medical assistance fee schedule, whether or not subject to the Medicare competitive bid that took effect in January of 2009, shall be increased by 2.94 percent, with this increase being applied after calculation of any increased payment rate under clause (1).

This paragraph does not apply to medical supplies and durable medical equipment subject to a volume purchase contract, products subject to the preferred diabetic testing supply program, items provided to dually eligible recipients when Medicare is the primary payer for the item, and individually priced items identified in paragraph (i). Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect the rate increases in this paragraph.

(k) Effective for nonpressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective

for pressure support ventilators provided on or after January 1, 2016, the rate shall be the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For payments made in accordance with this paragraph, if, and to the extent that, the commissioner identifies that the state has received federal financial participation for ventilators in excess of the amount allowed effective January 1, 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and Medicaid Services with state funds and maintain the full payment rate under this paragraph.

(l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall not be applied to the items listed in this paragraph.

(m) For dates of service on or after July 1, 2023, through June 30, 2024, enteral nutrition and supplies must be paid according to this paragraph. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the department, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous fiscal year's rate per code and product combination. Data are sufficient if: (1) the department has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the department has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data are not available to calculate the 50th percentile for enteral products or supplies, the payment rate shall be the payment rate in effect on June 30, 2023.

(n) For dates of service on or after July 1, 2024, enteral nutrition and supplies must be paid according to this paragraph and updated annually each January 1. If sufficient data exists for a product or supply, payment must be based upon the 50th percentile of the usual and customary charges per product code submitted to the department for the previous calendar year, using only charges submitted per unit. Increases in rates resulting from the 50th percentile payment method must not exceed 150 percent of the previous year's rate per code and product combination. Data are sufficient if: (1) the department has at least 100 paid claim lines by at least ten different providers for a given product or supply; or (2) in the absence of the data in clause (1), the department has at least 20 claim lines by at least five different providers for a product or supply that does not meet the requirements of clause (1). If sufficient data is not available to calculate the 50th percentile for enteral products or supplies, the payment shall be the manufacturer's suggested retail price of that product or

supply minus 20 percent. If the manufacturer's suggested retail price is not available, payment shall be the actual acquisition cost of that product or supply plus 20 percent.

ARTICLE 4
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 4.046, subdivision 6, is amended to read:

Subd. 6. **~~Addiction and recovery~~ Office of Addiction and Recovery; director.** An Office of Addiction and Recovery is created in the Department of Management and Budget. The governor must appoint an addiction and recovery director, who shall serve as chair of the subcabinet and administer the Office of Addiction and Recovery. The director shall serve in the unclassified service and shall report to the governor. The director must:

(1) make efforts to break down silos and work across agencies to better target the state's role in addressing addiction, treatment, and recovery;

(2) assist in leading the subcabinet and the advisory council toward progress on measurable goals that track the state's efforts in combatting addiction; and

(3) establish and manage external partnerships and build relationships with communities, community leaders, and those who have direct experience with addiction to ensure that all voices of recovery are represented in the work of the subcabinet and advisory council.

Sec. 2. Minnesota Statutes 2022, section 4.046, subdivision 7, is amended to read:

Subd. 7. **Staff and administrative support.** The commissioner of ~~human services~~ management and budget, in coordination with other state agencies and boards as applicable, must provide staffing and administrative support to the addiction and recovery director, the subcabinet, ~~and~~ the advisory council, and the Office of Addiction and Recovery established in this section.

Sec. 3. Minnesota Statutes 2022, section 4.046, is amended by adding a subdivision to read:

Subd. 8. **Division of Youth Substance Use and Addiction Recovery.** (a) A Division of Youth Substance Use and Addiction Recovery is created in the Office of Addiction and Recovery to focus on preventing adolescent substance use and addiction. The addiction and recovery director shall employ a director to lead the Division of Youth Substance Use and Addiction Recovery and staff necessary to fulfill its purpose.

(b) The director of the division shall:

(1) make efforts to bridge mental health and substance abuse treatment silos and work across agencies to focus the state's role and resources in preventing youth substance use and addiction;

(2) develop and share resources on evidence-based strategies and programs for addressing youth substance use and prevention;

(3) establish and manage external partnerships and build relationships with communities, community leaders, and persons and organizations with direct experience with youth substance use and addiction; and

(4) work to achieve progress on established measurable goals that track the state's efforts in preventing substance use and addiction among the state's youth population.

Sec. 4. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 4a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the meaning provided in section 254B.01, subdivision 2a.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 5. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person can take to reduce the negative impact of certain issues, such as substance use disorders, mental health disorders, and risk of suicide. Protective factors include connecting to positive supports in the community, a good diet, exercise, attending counseling or 12-step groups, and taking medications.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 6. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities

of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 7. Minnesota Statutes 2022, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** ~~(a)~~ A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within ~~three~~ five calendar days from the day of service initiation for a residential program or ~~within three calendar days on which a treatment session has been provided of the day of service initiation for a client~~ by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:~~

~~(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;~~

~~(2) a description of the circumstances on the day of service initiation;~~

~~(3) a list of previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;~~

~~(4) a list of substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and address the absence or presence of previous withdrawal symptoms;~~

~~(5) specific problem behaviors exhibited by the client when under the influence of substances;~~

~~(6) the client's desire for family involvement in the treatment program, family history of substance use and misuse, history or presence of physical or sexual abuse, and level of family support;~~

~~(7) physical and medical concerns or diagnoses, current medical treatment needed or being received related to the diagnoses, and whether the concerns need to be referred to an appropriate health care professional;~~

~~(8) mental health history, including symptoms and the effect on the client's ability to function; current mental health treatment; and psychotropic medication needed to maintain stability. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

~~(9) arrests and legal interventions related to substance use;~~

~~(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;~~

~~(11) ability to understand written treatment materials, including rules and the client's rights;~~

~~(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;~~

~~(13) social network in relation to expected support for recovery;~~

~~(14) leisure time activities that are associated with substance use;~~

~~(15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;~~

~~(16) whether the client recognizes needs related to substance use and is willing to follow treatment recommendations; and~~

~~(17) information from a collateral contact may be included, but is not required.~~

~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:~~

~~(1) risks for opioid use disorder and dependence;~~

~~(2) treatment options, including the use of a medication for opioid use disorder;~~

~~(3) the risk of and recognizing opioid overdose; and~~

~~(4) the use, availability, and administration of naloxone to respond to opioid overdose.~~

~~(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

~~(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:~~

~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

~~(2) the client has severe medical problems that require immediate attention; or~~

~~(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.~~

~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.~~ An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 8. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to read:

Subd. 3. **Comprehensive assessment requirements.** (a) A comprehensive assessment must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c). A comprehensive assessment must also include:

(1) a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder;

(2) a determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section

245.4863, except when the comprehensive assessment is being completed as part of a diagnostic assessment; and

(3) a recommendation for the ASAM level of care identified in section 254B.19, subdivision 1.

(b) If the individual is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

If the client is identified as having opioid use disorder at a later point, the education must be provided at that point. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 9. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program ~~and within five calendar days~~ by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol

and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 10. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 1a. **Individual treatment plan contents and process.** (a) After completing a client's comprehensive assessment, the license holder must complete an individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's comprehensive assessment;

(2) use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's individual treatment services, assessments, and treatment planning;

(3) identify the client's treatment goals in relation to any or all of the applicable ASAM six dimensions identified in section 254B.04, subdivision 4, to ensure measurable treatment objectives, a treatment strategy, and a schedule for accomplishing the client's treatment goals and objectives;

(4) document in the treatment plan the ASAM level of care identified in section 254B.19, subdivision 1, that the client is receiving services under;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) identify resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(7) identify maintenance strategy goals and methods designed to address relapse prevention and to strengthen the client's protective factors.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 11. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be ~~entered in a client's file weekly or after each treatment service, whichever is less frequent,~~ completed by the

alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review ~~and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c)~~. The review must:

(1) ~~address each goal in the~~ document client goals addressed since the last treatment plan review and whether the identified methods ~~to address the goals are~~ continue to be effective;

(2) ~~include~~ document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or natural supports;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; ~~and~~

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65~~.~~; and

(6) document any referrals made since the previous treatment plan review.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 12. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that the alcohol and drug counselor responsible for a client's treatment plan completes and documents a treatment plan review that meets the requirements of subdivision 3 in each client's file according to the frequencies required in this subdivision. All ASAM levels referred to in this chapter are those described in section 254B.19, subdivision 1.

(b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services or residential hospital-based services, a treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving nonresidential opioid treatment program services according to section 245G.22, a treatment plan review must be completed weekly for the ten weeks following completion of the treatment plan and monthly thereafter. Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) Notwithstanding paragraphs (e) and (f), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 13. Minnesota Statutes 2022, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section ~~245G.05, subdivision 2, paragraph (c)~~ 254B.04, subdivision 4, and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section ~~245G.05~~ 254B.04, subdivision 4;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis.

Sec. 14. Minnesota Statutes 2022, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision ~~1~~ 3, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) ~~an assessment summary completed according to section 245G.05, subdivision 2;~~

~~(5)~~ an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

~~(6)~~ (5) an individual treatment plan according to section 245G.06, subdivisions 1 and ~~2~~ 1a;

~~(7)~~ (6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, ~~and~~ 3, and 3a; and

~~(8)~~ (7) a summary at the time of service termination according to section 245G.06, subdivision 4.

Sec. 15. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period,~~

~~and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service was provided, the license holder must ensure the service is documented according to the requirements in section 245G.06, subdivision 2a.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

~~(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:~~

~~(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;~~

~~(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and~~

~~(3) for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently.~~

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 16. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, specifically withdrawal, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment; ~~and~~

(10) cultural influences on the client~~.~~; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Sec. 17. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

Sec. 18. Minnesota Statutes 2022, section 254B.01, subdivision 8, is amended to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from ~~alcohol and other drug addiction~~ substance use disorder. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

Sec. 19. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Sec. 20. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Comprehensive assessment.** "Comprehensive assessment" means a person-centered, trauma-informed assessment that:

(1) is completed for a substance use disorder diagnosis, treatment planning, and determination of client eligibility for substance use disorder treatment services;

(2) meets the requirements in section 245G.05; and

(3) is completed by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5.

Sec. 21. Minnesota Statutes 2022, section 254B.04, is amended by adding a subdivision to read:

Subd. 4. **Assessment criteria and risk descriptions.** (a) A level of care determination must use the following criteria to assess risk:

(b) Dimension 1: Acute intoxication and withdrawal potential. A vendor must use the following scoring and criteria in Dimension 1 to determine a client's acute intoxication and withdrawal potential, the client's ability to cope with withdrawal symptoms, and the client's current state of intoxication.

"0" The client displays full functioning with good ability to tolerate and cope with withdrawal discomfort, and the client shows no signs or symptoms of intoxication or withdrawal or diminishing signs or symptoms.

"1" The client can tolerate and cope with withdrawal discomfort. The client displays mild-to-moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. The client poses a minimal risk of severe withdrawal.

"2" The client has some difficulty tolerating and coping with withdrawal discomfort. The client's intoxication may be severe, but the client responds to support and treatment such that the client does not immediately endanger self or others. The client displays moderate signs and symptoms of withdrawal with moderate risk of severe withdrawal.

"3" The client tolerates and copes with withdrawal discomfort poorly. The client has severe intoxication, such that the client endangers self or others, or intoxication has not abated with less intensive services. The client displays severe signs and symptoms of withdrawal, has a risk of severe-but-manageable withdrawal, or has worsening withdrawal despite detoxification at less intensive level.

"4" The client is incapacitated with severe signs and symptoms. The client displays severe withdrawal and is a danger to self or others.

(c) Dimension 2: biomedical conditions and complications. The vendor must use the following scoring and criteria in Dimension 2 to determine a client's biomedical conditions and complications, the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. If the client is pregnant, the provider must determine the impact of continued substance use on the unborn child.

"0" The client displays full functioning with good ability to cope with physical discomfort.

"1" The client tolerates and copes with physical discomfort and is able to get the services that the client needs.

"2" The client has difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and treatment. The client neglects or does not seek care for serious biomedical problems.

"3" The client tolerates and copes poorly with physical problems or has poor general health. The client neglects the client's medical problems without active assistance.

"4" The client is unable to participate in substance use disorder treatment and has severe medical problems, a condition that requires immediate intervention, or is incapacitated.

(d) Dimension 3: Emotional, behavioral, and cognitive conditions and complications. The vendor must use the following scoring and criteria in Dimension 3 to determine a client's emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas; and the likelihood of harm to self or others.

"0" The client has good impulse control and coping skills and presents no risk of harm to self or others. The client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

"1" The client has impulse control and coping skills. The client presents a mild to moderate risk of harm to self or others or displays symptoms of emotional, behavioral, or cognitive problems. The client has a mental health diagnosis and is stable. The client functions adequately in significant life areas.

"2" The client has difficulty with impulse control and lacks coping skills. The client has thoughts of suicide or harm to others without means, however the thoughts may interfere with participation in some activities. The client has difficulty functioning in significant life areas. The client has moderate symptoms of emotional, behavioral, or cognitive problems. The client is able to participate in most treatment activities.

"3" The client has a severe lack of impulse control and coping skills. The client also has frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. In addition, the client is severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in treatment activities.

"4" The client has severe emotional or behavioral symptoms that place the client or others at acute risk of harm. The client also has intrusive thoughts of harming self or others. The client is unable to participate in treatment activities.

(e) Dimension 4: Readiness for change. The vendor must use the following scoring and criteria in Dimension 4 to determine a client's readiness for change and the support necessary to keep the client involved in treatment services.

"0" The client is cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.

"1" The client is motivated with active reinforcement to explore treatment and strategies for change but ambivalent about illness or need for change.

"2" The client displays verbal compliance, but lacks consistent behaviors, has low motivation for change, and is passively involved in treatment.

"3" The client displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.

"4" The client is:

(i) noncompliant with treatment and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the client's illness and its implications; or

(ii) the client is dangerously oppositional to the extent that the client is a threat of imminent harm to self and others.

(f) Dimension 5: Relapse, continued use, and continued problem potential. The vendor must use the following scoring and criteria in Dimension 5 to determine a client's relapse, continued use, and continued problem potential and the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

"0" The client recognizes risk well and is able to manage potential problems.

"1" The client recognizes relapse issues and prevention strategies but displays some vulnerability for further substance use or mental health problems.

"2" The client has:

(i) minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems; or

(ii) some coping skills inconsistently applied.

"3" The client has poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. The client has few coping skills and rarely applies coping skills.

"4" The client has no coping skills to arrest mental health or addiction illnesses or prevent relapse. The client has no recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use disorder or mental health problems.

(g) Dimension 6: Recovery environment. The vendor must use the following scoring and criteria in Dimension 6 to determine a client's recovery environment, whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

"0" The client is engaged in structured meaningful activity and has a supportive significant other, family, and living environment.

"1" The client has passive social network support, or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.

"2" The client is engaged in structured, meaningful activity, but peers, family, significant other, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant other, or in the client's living environment.

"3" The client is not engaged in structured meaningful activity, and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.

"4" The client has:

(i) a chronically antagonistic significant other, living environment, family, peer group, or a long-term criminal justice involvement that is harmful to recovery or treatment progress; or

(ii) an actively antagonistic significant other, family, work, or living environment that poses an immediate threat to the client's safety and well-being.

Sec. 22. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. ~~**Licensure required**~~ **Eligible vendors.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization ~~that meets certification requirements identified by the commissioner~~ certified by the Board of Recovery Services under sections 254B.20 to 254B.24 is an eligible vendor of peer support services.

(e) Recovery community organizations directly approved by the commissioner of human services before June 30, 2023, will retain their designation as a recovery community organization.

~~(e)~~ (f) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

Sec. 23. Minnesota Statutes 2022, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) ~~outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~ those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided by the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) ~~care~~ treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) ~~on July 1, 2019, or upon federal approval, whichever is later,~~ withdrawal management services provided according to chapter 245F;

(6) substance use disorder treatment services with medications for opioid use disorder ~~that are~~ provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) substance use disorder treatment with medications for opioid use disorder plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;~~

~~(9)~~ (7) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (8) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11) high-intensity residential treatment~~ (9) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide ~~30 hours of clinical services each week~~ ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and is provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(12)~~ (10) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and substance use disorder problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) ~~Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner~~ Payment for substance use disorder services under this section must start from the day of service initiation when the comprehensive assessment is completed within the required timelines.

EFFECTIVE DATE. The amendments to paragraph (b), clause (1), items (i) to (iv), are effective January 1, 2025, or upon federal approval, whichever is later. The amendments

to paragraph (b), clause (1), items (v) to (vii), are effective January 1, 2024, or upon federal approval, whichever is later. The amendments to paragraph (b), clauses (2) to (10), are effective January 1, 2024.

Sec. 24. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.**

Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level of care, eligible vendors must implement the standards set by the ASAM for the respective level of care. Additionally, vendors must meet the following requirements.

(1) For ASAM level 0.5 early intervention targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed substance use disorder, early intervention services may include individual or group counseling, treatment coordination, peer recovery support, screening brief intervention, and referral to treatment provided according to section 254A.03, subdivision 3, paragraph (c).

(2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services must be licensed according to section 245G.20 and meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week.

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of skilled treatment services. Services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need daily monitoring in a structured setting as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of skilled treatment services per week according to each client's specific treatment schedule as directed by the individual treatment plan. Programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759.

(6) For ASAM level 3.3 clinically managed population-specific high-intensity residential clients, programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage. Programs must be enrolled as a disability responsive program as described in section 254B.01, subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective. Programs must provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(7) For ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage and provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal management must be provided according to chapter 245F.

(9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal management must be provided according to chapter 245F.

Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain documentation of a formal patient referral arrangement agreement for each of the following levels of care not provided by the license holder:

(1) level 1.0 outpatient;

(2) level 2.1 intensive outpatient;

(3) level 2.5 partial hospitalization;

(4) level 3.1 clinically managed low-intensity residential;

(5) level 3.3 clinically managed population-specific high-intensity residential;

(6) level 3.5 clinically managed high-intensity residential;

(7) level withdrawal management 3.2 clinically managed residential withdrawal management; and

(8) level withdrawal management 3.7 medically monitored inpatient withdrawal management.

Subd. 3. **Evidence-based practices.** All services delivered within the ASAM levels of care referenced in subdivision 1, clauses (1) to (7), must have documentation of the evidence-based practices being utilized as referenced in the most current edition of the ASAM criteria.

Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach plan. The treatment director must document a review and update the plan annually. The program outreach plan must include treatment coordination strategies and processes to ensure seamless transitions across the continuum of care. The plan must include how the provider will:

(1) increase the awareness of early intervention treatment services, including but not limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

(2) coordinate, as necessary, with certified community behavioral health clinics when a license holder is located in a geographic region served by a certified community behavioral health clinic;

(3) establish a referral arrangement agreement with a withdrawal management program licensed under chapter 245F when a license holder is located in a geographic region in which a withdrawal management program is licensed under chapter 245F. If a withdrawal management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(4) coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(5) develop and maintain collaboration with local county and Tribal human services agencies; and

(6) collaborate with primary care and mental health settings.

Sec. 25. **[254B.191] EVIDENCE-BASED TRAINING.**

The commissioner must establish ongoing training opportunities for substance use disorder treatment providers under chapter 245F to increase knowledge and develop skills to adopt evidence-based and promising practices in substance use disorder treatment programs. Training opportunities must support the transition to ASAM standards. Training formats may include self or organizational assessments, virtual modules, one-to-one coaching, self-paced courses, interactive hybrid courses, and in-person courses. Foundational and skill-building training topics may include:

(1) ASAM criteria;

(2) person-centered and culturally responsive services;

(3) medical and clinical decision making;

(4) conducting assessments and appropriate level of care;

(5) treatment and service planning;

(6) identifying and overcoming systems challenges;

(7) conducting clinical case reviews; and

(8) appropriate and effective transfer and discharge.

Sec. 26. **[254B.20] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 254B.20 to 254B.24, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the Board of Recovery Services established by section 254B.21.

Subd. 3. **Credential or credentialing.** "Credential" or "credentialing" means the standardized process of formally reviewing and designating a recovery organization as qualified to employ peer recovery specialists based on criteria established by the board.

Subd. 4. **Minnesota Certification Board.** "Minnesota Certification Board" means the nonprofit agency member board of the International Certification and Reciprocity Consortium that sets the policies and procedures for alcohol and other drug professional certifications in Minnesota, including peer recovery specialists.

Subd. 5. **Peer recovery specialist.** "Peer recovery specialist" has the meaning given to "recovery peer" in section 245F.02, subdivision 21. A peer recovery specialist must meet the qualifications of a recovery peer in section 245G.11, subdivision 8.

Subd. 6. **Peer recovery services.** "Peer recovery services" has the meaning given to "peer recovery support services" in section 245F.02, subdivision 17.

Sec. 27. **[254B.21] MINNESOTA BOARD OF RECOVERY SERVICES.**

Subdivision 1. **Creation.** (a) The Minnesota Board of Recovery Services is established and consists of 13 members appointed by the governor as follows:

(1) five of the members must be certified peer recovery specialists certified under the Minnesota Certification Board with an active credential;

(2) two of the members must be certified peer recovery specialist supervisors certified under the Minnesota Certification Board with an active credential;

(3) four of the members must be currently employed by a Minnesota-based recovery community organization recognized by the commissioner of human services; and

(4) two of the members must be public members as defined in section 214.02, and be either a family member of a person currently using substances or a person in recovery from a substance use disorder.

(b) At the time of their appointments, at least three members must reside outside of the seven-county metropolitan area.

(c) At the time of their appointments, at least three members must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Subd. 2. **Officers.** The board must annually elect a chair and vice-chair from among its members and may elect other officers as necessary. The board must meet at least twice a year but may meet more frequently at the call of the chair.

Subd. 3. **Membership terms; compensation.** Membership terms, compensation of members, removal of members, the filling of membership vacancies, and fiscal year and reporting requirements are as provided in section 15.058.

Subd. 4. **Expiration.** The board does not expire.

Sec. 28. **[254B.22] DUTIES OF THE BOARD.**

The Minnesota Board of Recovery Services shall:

(1) develop and define by rule criteria for credentialing recovery organizations using nationally recognized best practices and standards;

(2) determine the renewal cycle and renewal period for eligible vendors of peer recovery services;

(3) receive, review, approve, or disapprove initial applications, renewals, and reinstatement requests for credentialing from recovery organizations;

(4) establish administrative procedures for processing applications submitted under clause (3) and hire or appoint such agents as are appropriate for processing applications;

(5) retain records of board actions and proceedings in accordance with public records laws; and

(6) establish, maintain, and publish annually a register of current credentialed recovery organizations.

Sec. 29. **[254B.23] REQUIREMENTS FOR CREDENTIALING.**

Subdivision 1. **Application requirements.** An application submitted to the board for credentialing must include:

(1) evidence that the applicant is a nonprofit organization based in Minnesota or meets the eligibility criteria defined by the board;

(2) a description of the applicant's activities and services that support recovery from substance use disorder; and

(3) any other requirements as specified by the board.

Subd. 2. **Fee.** Each applicant must pay a nonrefundable application fee as established by the board. The revenue from the fee must be deposited in the state government special revenue fund.

Sec. 30. **[254B.24] APPEAL AND HEARING.**

A recovery organization aggrieved by the board's failure to issue, renew, or reinstate credentialing under sections 254B.20 to 254B.24 may appeal by requesting a hearing under the procedures of chapter 14.

Sec. 31. **[254B.30] PROJECT ECHO GRANTS.**

Subdivision 1. **Establishment.** The commissioner must establish a grant program to support new or existing Project ECHO programs in the state.

Subd. 2. **Project ECHO at Hennepin Healthcare.** The commissioner must use appropriations under this subdivision to award grants to Hennepin Healthcare to establish at least four substance use disorder-focused Project ECHO programs, expanding the grantee's capacity to improve health and substance use disorder outcomes for diverse populations of individuals enrolled in medical assistance, including but not limited to immigrants, individuals who are homeless, individuals seeking maternal and perinatal care, and other underserved populations. The Project ECHO programs funded under this subdivision must be culturally responsive, and the grantee must contract with culturally and linguistically appropriate substance use disorder service providers who have expertise in focus areas, based on the populations served. Grant funds may be used for program administration, equipment, provider reimbursement, and staffing hours.

Sec. 32. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter and are licensed as a hospital under sections 144.50 to 144.581 must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025.

~~(c)~~ (d) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3

by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(d)~~ (e) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

~~(e)~~ (f) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal nations to discuss participation in the substance use disorder demonstration project.

~~(f)~~ (g) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

~~(g)~~ (h) The commissioner may recoup any rate enhancements paid under paragraph ~~(f)~~ (g) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Sec. 33. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision to read:

Subd. 1s. **Supplemental rate; Douglas County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2023, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Douglas County that operates a long-term residential facility with a total

of 74 beds that serve chemically dependent men and provide 24-hour-a-day supervision and other support services.

Sec. 34. Minnesota Statutes 2022, section 256I.05, is amended by adding a subdivision to read:

Subd. 1t. **Supplemental rate; Crow Wing County.** Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2023, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $750 per month, including any legislatively authorized inflationary adjustments, for a housing support provider located in Crow Wing County that operates a long-term residential facility with a total of 90 beds that serve chemically dependent men and women and provides 24-hour-a-day supervision and other support services.

Sec. 35. **[325F.725] SOBER HOME TITLE PROTECTION.**

No person or entity may use the phrase "sober home," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that provides temporary housing to persons with a substance use disorder, does not provide counseling or treatment services to residents, promotes sustained recovery from substance use disorders, and follows the sober living guidelines published by the federal Substance Abuse and Mental Health Services Administration.

Sec. 36. **CULTURALLY RESPONSIVE RECOVERY COMMUNITY GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new recovery community organizations serving or intending to serve culturally specific or population-specific recovery communities. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring and retaining staff;

(2) staff training, purchasing office equipment and supplies;

(3) purchasing software and website services;

(4) costs associated with establishing nonprofit status;

(5) rental and lease costs and community outreach; and

(6) education and recovery events.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 37. **WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new withdrawal management programs that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; and

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 38. **FAMILY TREATMENT START-UP AND CAPACITY-BUILDING GRANTS.**

The commissioner must establish start-up and capacity-building grants for prospective or new substance use disorder treatment programs that serve parents with their children. Grants must be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) physical plant upgrades to support larger family units;

(2) supporting the expansion or development of programs that provide holistic services, including trauma supports, conflict resolution, and parenting skills;

(3) increasing awareness, education, and outreach utilizing culturally responsive approaches to develop relationships between culturally specific communities and clinical treatment provider programs; and

(4) expanding culturally specific family programs and accommodating diverse family units.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 39. **MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY.**

The commissioner, in consultation with stakeholders, must evaluate the feasibility, potential design, and federal authorities needed to cover traditional healing, behavioral health services in correctional facilities, and contingency management under the medical assistance program.

Sec. 40. **REVISED PAYMENT METHODOLOGY FOR OPIOID TREATMENT PROGRAMS.**

The commissioner must revise the payment methodology for substance use services with medications for opioid use disorder under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). Payment must occur only if the provider renders the service or services billed on that date of service or, in the case of drugs and drug-related services, within a week as defined by the commissioner. The revised payment methodology must include a weekly bundled rate that includes the costs of drugs, drug administration and observation, drug packaging and preparation, and nursing time. The bundled weekly rate must be based on the Medicare rate. The commissioner must seek all necessary waivers, state plan amendments, and federal authorities required to implement the revised payment methodology.

EFFECTIVE DATE. This section is effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any necessary changes to cross-references.

Sec. 42. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245G.05, subdivision 2; and 256B.0759, subdivision 6, are repealed.

(b) Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2024. Paragraph (b) is effective July 1, 2023.

ARTICLE 5
SUBSTANCE USE DISORDER

Section 1. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids

in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor, the commissioner shall deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph ~~(d)~~ (e).

Sec. 2. **[121A.224] OPIATE ANTAGONISTS.**

(a) A school district or charter school must maintain a supply of opiate antagonists, as defined in section 604A.04, subdivision 1, at each school site to be administered in compliance with section 151.37, subdivision 12.

(b) Each school building must have two doses of nasal naloxone available on site.

(c) The commissioner of health must develop and disseminate to schools a short training video about how and when to administer nasal naloxone. The person having control of the school building must ensure that at least one staff member trained on how and when to administer nasal naloxone is on site when the school building is open to students, staff, or the public, including before school, after school, or weekend activities.

EFFECTIVE DATE. This section is effective July 1, 2023.

Sec. 3. Minnesota Statutes 2022, section 151.065, subdivision 7, is amended to read:

Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state government special revenue fund.

(b) $5,000 of each fee collected under subdivision 1, clauses (6) to (9), and (11) to (15), and subdivision 3, clauses (4) to (7), and (9) to (13), and $55,000 of each fee collected under subdivision 1, clause (16), and subdivision 3, clause (14), shall be deposited in the opiate epidemic response fund established in section 256.043.

~~(c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14), are reduced under section 256.043, $5,000 of the reduced fee shall be deposited in the opiate epidemic response fund in section 256.043.~~

Sec. 4. Minnesota Statutes 2022, section 241.021, subdivision 1, is amended to read:

Subdivision 1. **Correctional facilities; inspection; licensing.** (a) Except as provided in paragraph (b), the commissioner of corrections shall inspect and license all correctional facilities throughout the state, whether public or private, established and operated for the detention and confinement of persons confined or incarcerated therein according to law except to the extent that they are inspected or licensed by other state regulating agencies. The commissioner shall promulgate pursuant to chapter 14, rules establishing minimum standards for these facilities with respect to their management, operation, physical condition, and the security, safety, health, treatment, and discipline of persons confined or incarcerated therein. These minimum standards shall include but are not limited to specific guidance pertaining to:

(1) screening, appraisal, assessment, and treatment for persons confined or incarcerated in correctional facilities with mental illness or substance use disorders;

(2) a policy on the involuntary administration of medications;

(3) suicide prevention plans and training;

(4) verification of medications in a timely manner;

(5) well-being checks;

(6) discharge planning, including providing prescribed medications to persons confined or incarcerated in correctional facilities upon release;

(7) a policy on referrals or transfers to medical or mental health care in a noncorrectional institution;

(8) use of segregation and mental health checks;

(9) critical incident debriefings;

(10) clinical management of substance use disorders and opioid overdose emergency procedures;

(11) a policy regarding identification of persons with special needs confined or incarcerated in correctional facilities;

(12) a policy regarding the use of telehealth;

(13) self-auditing of compliance with minimum standards;

(14) information sharing with medical personnel and when medical assessment must be facilitated;

(15) a code of conduct policy for facility staff and annual training;

(16) a policy on death review of all circumstances surrounding the death of an individual committed to the custody of the facility; and

(17) dissemination of a rights statement made available to persons confined or incarcerated in licensed correctional facilities.

No individual, corporation, partnership, voluntary association, or other private organization legally responsible for the operation of a correctional facility may operate the facility unless it possesses a current license from the commissioner of corrections. Private adult correctional facilities shall have the authority of section 624.714, subdivision 13, if the Department of Corrections licenses the facility with the authority and the facility meets requirements of section 243.52.

The commissioner shall review the correctional facilities described in this subdivision at least once every two years, except as otherwise provided, to determine compliance with the minimum standards established according to this subdivision or other Minnesota statute related to minimum standards and conditions of confinement.

The commissioner shall grant a license to any facility found to conform to minimum standards or to any facility which, in the commissioner's judgment, is making satisfactory progress toward substantial conformity and the standards not being met do not impact the interests and well-being of the persons confined or incarcerated in the facility. A limited license under subdivision 1a may be issued for purposes of effectuating a facility closure. The commissioner may grant licensure up to two years. Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license.

The commissioner shall have access to the buildings, grounds, books, records, staff, and to persons confined or incarcerated in these facilities. The commissioner may require the officers in charge of these facilities to furnish all information and statistics the commissioner deems necessary, at a time and place designated by the commissioner.

All facility administrators of correctional facilities are required to report all deaths of individuals who died while committed to the custody of the facility, regardless of whether the death occurred at the facility or after removal from the facility for medical care stemming from an incident or need for medical care at the correctional facility, as soon as practicable, but no later than 24 hours of receiving knowledge of the death, including any demographic information as required by the commissioner.

All facility administrators of correctional facilities are required to report all other emergency or unusual occurrences as defined by rule, including uses of force by facility staff that result in substantial bodily harm or suicide attempts, to the commissioner of corrections within ten days from the occurrence, including any demographic information as required by the commissioner. The commissioner of corrections shall consult with the Minnesota Sheriffs' Association and a representative from the Minnesota Association of Community Corrections Act Counties who is responsible for the operations of an adult correctional facility to define "use of force" that results in substantial bodily harm for reporting purposes.

The commissioner may require that any or all such information be provided through the Department of Corrections detention information system. The commissioner shall post each inspection report publicly and on the department's website within 30 days of completing the inspection. The education program offered in a correctional facility for the confinement or incarceration of juvenile offenders must be approved by the commissioner of education before the commissioner of corrections may grant a license to the facility.

(b) For juvenile facilities licensed by the commissioner of human services, the commissioner may inspect and certify programs based on certification standards set forth in Minnesota Rules. For the purpose of this paragraph, "certification" has the meaning given it in section 245A.02.

(c) Any state agency which regulates, inspects, or licenses certain aspects of correctional facilities shall, insofar as is possible, ensure that the minimum standards it requires are substantially the same as those required by other state agencies which regulate, inspect, or license the same aspects of similar types of correctional facilities, although at different correctional facilities.

(d) Nothing in this section shall be construed to limit the commissioner of corrections' authority to promulgate rules establishing standards of eligibility for counties to receive funds under sections 401.01 to 401.16, or to require counties to comply with operating standards the commissioner establishes as a condition precedent for counties to receive that funding.

(e) The department's inspection unit must report directly to a division head outside of the correctional institutions division.

Sec. 5. Minnesota Statutes 2022, section 241.31, subdivision 5, is amended to read:

Subd. 5. **Minimum standards.** The commissioner of corrections shall establish minimum standards for the size, area to be served, qualifications of staff, ratio of staff to client population, and treatment programs for community corrections programs established pursuant to this section. Plans and specifications for such programs, including proposed budgets must first be submitted to the commissioner for approval prior to the establishment. Community corrections programs must maintain a supply of opiate antagonists, as defined in section 604A.04, subdivision 1, at each correctional site to be administered in compliance with section 151.37, subdivision 12. Each site must have at least two doses of naloxone on site. Staff must be trained on how and when to administer opiate antagonists.

Sec. 6. Minnesota Statutes 2022, section 241.415, is amended to read:

241.415 RELEASE PLANS; SUBSTANCE ABUSE.

The commissioner shall cooperate with community-based corrections agencies to determine how best to address the substance abuse treatment needs of offenders who are being released from prison. The commissioner shall ensure that an offender's prison release plan adequately addresses the offender's needs for substance abuse assessment, treatment, or other services following release, within the limits of available resources. The commissioner must provide individuals with known or stated histories of opioid use disorder with emergency opiate antagonist rescue kits upon release.

Sec. 7. **[245.89] PUBLIC AWARENESS CAMPAIGN.**

(a) The commissioner must establish an ongoing, multitiered public awareness and educational campaign on substance use disorders. The campaign must include strategies to prevent substance use disorder, reduce stigma, and ensure people know how to access treatment, recovery, and harm reduction services.

(b) The commissioner must consult with communities disproportionately impacted by substance use disorder to ensure the campaign centers lived experience and equity. The commissioner may also consult with and establish relationships with media and communication experts, behavioral health professionals, state and local agencies, and community organizations to design and implement the campaign.

(c) The campaign must include awareness-raising and educational information using multichannel marketing strategies, social media, virtual events, press releases, reports, and targeted outreach. The commissioner must evaluate the effectiveness of the campaign and modify outreach and strategies as needed.

Sec. 8. **[245.891] OVERDOSE SURGE ALERT SYSTEM.**

The commissioner must establish a statewide overdose surge text message alert system. The system may include other forms of electronic alerts. The purpose of the system is to prevent opioid overdose by cautioning people to refrain from substance use or to use harm-reduction strategies when there is an overdose surge in the surrounding area. The commissioner may collaborate with local agencies, other state agencies, and harm-reduction organizations to promote and improve the voluntary text service.

Sec. 9. **[245.892] HARM-REDUCTION AND CULTURALLY SPECIFIC GRANTS.**

(a) The commissioner must establish grants for Tribal Nations or culturally specific organizations to enhance and expand capacity to address the impacts of the opioid epidemic in their respective communities. Grants may be used to purchase and distribute harm-reduction supplies, develop organizational capacity, and expand culturally specific services.

(b) Harm-reduction grant funds must be used to promote safer practices and reduce the transmission of infectious disease. Allowable expenses include fentanyl-testing supplies, disinfectants, naloxone rescue kits, sharps disposal, wound-care supplies, medication lock boxes, FDA-approved home testing kits for viral hepatitis and HIV, and written educational and resource materials.

(c) Culturally specific organizational capacity grant funds must be used to develop and improve organizational infrastructure to increase access to culturally specific services and community building. Allowable expenses include funds for organizations to hire staff or consultants who specialize in fundraising, grant writing, business development, and program integrity or other identified organizational needs as approved by the commissioner.

(d) Culturally specific service grant funds must be used to expand culturally specific outreach and services. Allowable expenses include hiring or consulting with cultural advisors, resources to support cultural traditions, and education to empower, develop a sense of community, and develop a connection to ancestral roots.

(e) Training grant funds may be used to provide information and training on safe storage and use of opiate antagonists. Training may be conducted via multiple modalities, including but not limited to in-person, virtual, written, and video recordings.

Sec. 10. Minnesota Statutes 2022, section 245G.08, subdivision 3, is amended to read:

Subd. 3. ~~**Standing order protocol**~~ **Emergency overdose treatment.** A license holder ~~that maintains~~ must maintain a supply of ~~naloxone~~ opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose and must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of naloxone on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both.

Sec. 11. Minnesota Statutes 2022, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from registration and license fee account.** (a) The appropriations in paragraphs (b) to ~~(h)~~ (j) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for overdose antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal Nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(e) $400,000 is appropriated to the commissioner of human services for grants of $200,000 to CHI St. Gabriel's Health Family Medical Center for the opioid-focused Project ECHO program and $200,000 to Hennepin Health Care for the opioid-focused Project ECHO program.

~~(e)~~ (f) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

~~(d)~~ (g) $249,000 ~~is~~ in fiscal year 2023, $375,000 in fiscal year 2024, and $315,000 each year thereafter are appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph ~~(h)~~ (k).

~~(e)~~ (h) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

~~(f)~~ (i) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

~~(g)~~ (j) After the appropriations in paragraphs (b) to ~~(f)~~ (i) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

~~(h)~~ (k) After the appropriations in paragraphs (b) to ~~(g)~~ (j) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

~~(i)~~ (l) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph ~~(g)~~ (j) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph ~~(h)~~ (k) may be distributed on a calendar year basis.

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

Sec. 12. Minnesota Statutes 2022, section 256.043, subdivision 3a, is amended to read:

Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs (b) to (e) shall be made from the settlement account on a fiscal year basis in the order specified.

(b) If the balance in the registration and license fee account is not sufficient to fully fund the appropriations specified in subdivision 3, paragraphs (b) to ~~(f)~~ (i), an amount necessary to meet any insufficiency shall be transferred from the settlement account to the registration and license fee account to fully fund the required appropriations.

(c) $209,000 in fiscal year 2023 and $239,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for the administration of grants awarded under paragraph (e). $276,000 in fiscal year 2023 and $151,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services to collect, collate, and report data submitted and to monitor compliance with reporting and settlement expenditure requirements by grantees awarded grants under this section and municipalities receiving direct payments from a statewide opioid settlement agreement as defined in section 256.042, subdivision 6.

(d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount equal to the calendar year allocation to Tribal social service agency initiative projects under subdivision 3, paragraph ~~(g)~~ (j), is appropriated from the settlement account to the commissioner of human services for distribution to Tribal social service agency initiative projects to provide child protection services to children and families who are affected by addiction. The requirements related to proportional distribution, annual reporting, and maintenance of effort specified in subdivision 3, paragraph ~~(g)~~ (j), also apply to the appropriations made under this paragraph.

(e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042.

(f) Funds for Tribal social service agency initiative projects under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) may be distributed on a calendar year basis.

(g) Notwithstanding section 16A.28, funds appropriated in paragraphs (d) and (e) are available for three years.

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

Sec. 13. **[256I.052] OPIATE ANTAGONISTS.**

(a) Site-based or group housing support settings must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, at each housing site to be administered in compliance with section 151.37, subdivision 12.

(b) Each site must have at least two doses of naloxone on site.

(c) Staff on site must have training on how and when to administer opiate antagonists.

Sec. 14. Laws 2019, chapter 63, article 3, section 1, as amended by Laws 2020, chapter 115, article 3, section 35, and Laws 2022, chapter 53, section 12, is amended to read:

Section 1. **APPROPRIATIONS.**

(a) **Board of Pharmacy; administration.** $244,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for onetime information technology and operating costs for administration of licensing activities under Minnesota Statutes, section 151.066. This is a onetime appropriation.

(b) **Commissioner of human services; administration.** $309,000 in fiscal year 2020 is appropriated from the general fund and $60,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraphs (f), (g), and (h). The opiate epidemic response fund base for this appropriation is $60,000 in fiscal year 2022, $60,000 in fiscal year 2023, ~~$60,000 in fiscal year 2024,~~ and $0 in fiscal year ~~2025~~ 2024.

(c) **Board of Pharmacy; administration.** $126,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(d) **Commissioner of public safety; enforcement activities.** $672,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of public safety for the

Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(e) **Commissioner of management and budget; evaluation activities.** $300,000 in fiscal year 2020 is appropriated from the general fund and $300,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of management and budget for evaluation activities under Minnesota Statutes, section 256.042, subdivision 1, paragraph (c).

(f) **Commissioner of human services; grants for Project ECHO.** $400,000 in fiscal year 2020 is appropriated from the general fund and $400,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for grants of $200,000 to CHI St. Gabriel's Health Family Medical Center for the opioid-focused Project ECHO program and $200,000 to Hennepin Health Care for the opioid-focused Project ECHO program. The opiate epidemic response fund base for this appropriation is $400,000 in fiscal year 2022, $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $0 in fiscal year 2025.

(g) **Commissioner of human services; opioid overdose prevention grant.** $100,000 in fiscal year 2020 is appropriated from the general fund and $100,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for a grant to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. ~~The opiate epidemic response fund base for this appropriation is $100,000 in fiscal year 2022, $100,000 in fiscal year 2023, $100,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

(h) **Commissioner of human services; traditional healing.** $2,000,000 in fiscal year 2020 is appropriated from the general fund and $2,000,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal nations and five urban Indian communities for traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. ~~The opiate epidemic response fund base for this appropriation is $2,000,000 in fiscal year 2022, $2,000,000 in fiscal year 2023, $2,000,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

(i) **Board of Dentistry; continuing education.** $11,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Dentistry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(j) **Board of Medical Practice; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Medical Practice to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(k) **Board of Nursing; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Nursing to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(l) **Board of Optometry; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Optometry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(m) **Board of Podiatric Medicine; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Podiatric Medicine to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(n) **Commissioner of health; nonnarcotic pain management and wellness.** $1,250,000 is appropriated in fiscal year 2020 from the general fund to the commissioner of health, to provide funding for:

(1) statewide mapping and assessment of community-based nonnarcotic pain management and wellness resources; and

(2) up to five demonstration projects in different geographic areas of the state to provide community-based nonnarcotic pain management and wellness resources to patients and consumers.

The demonstration projects must include an evaluation component and scalability analysis. The commissioner shall award the grant for the statewide mapping and assessment, and the demonstration project grants, through a competitive request for proposal process. Grants for statewide mapping and assessment and demonstration projects may be awarded simultaneously. In awarding demonstration project grants, the commissioner shall give

preference to proposals that incorporate innovative community partnerships, are informed and led by people in the community where the project is taking place, and are culturally relevant and delivered by culturally competent providers. This is a onetime appropriation.

(o) **Commissioner of health; administration.** $38,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of health for the administration of the grants awarded in paragraph (n).

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

Sec. 15. **OPIATE ANTAGONIST TRAINING GRANTS.**

The commissioner must establish grants to support training on how to safely store opiate antagonists, opioid overdose symptoms and identification, and how and when to administer opiate antagonists. Eligible grantees include correctional facilities or programs, housing programs, and substance use disorder programs.

ARTICLE 6
OPIOID PRESCRIBING IMPROVEMENT PROGRAM

Section 1. Minnesota Statutes 2022, section 256B.0638, subdivision 2, is amended to read:

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

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled as a medical assistance provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to ~~medical assistance and MinnesotaCare~~ Minnesota health care program enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Sec. 2. Minnesota Statutes 2022, section 256B.0638, subdivision 4, is amended to read:

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid ~~disenrollment~~ standards for opioid prescribers and provider groups~~. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards~~; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice

care or palliative care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Sec. 3. Minnesota Statutes 2022, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the ~~programs within the Minnesota health care~~ quality improvement program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner ~~shall~~ may take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Sec. 4. **REPEALER.**

Minnesota Statutes 2022, section 256B.0638, subdivisions 1, 2, 3, 4, 5, and 6, are repealed.

EFFECTIVE DATE. This section is effective June 30, 2024.

ARTICLE 7
DEPARTMENT OF DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2022, section 246.54, subdivision 1a, is amended to read:

Subd. 1a. **Anoka-Metro Regional Treatment Center.** (a) A county's payment of the cost of care provided at Anoka-Metro Regional Treatment Center shall be according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate for the client; and

(3) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged. The county is responsible for zero percent of the cost of care under this clause for a person committed

as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program.

Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

(b) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

Sec. 2. Minnesota Statutes 2022, section 246.54, subdivision 1b, is amended to read:

Subd. 1b. **Community behavioral health hospitals.** (a) A county's payment of the cost of care provided at state-operated community-based behavioral health hospitals for adults and children shall be according to the following schedule:

(1) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged except as provided under paragraph (b); and

(2) the county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

(b) The county is responsible for 50 percent of the cost of care under paragraph (a), clause (1), for a person committed as a person who has a mental illness and is dangerous to the public under section 253B.18 and who is awaiting transfer to another state-operated facility or program.

(c) Notwithstanding any law to the contrary, the client is not responsible for payment of the cost of care under this subdivision.

ARTICLE 8
APPROPRIATIONS

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

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.

"The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2024	2025

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

Subdivision 1. **Total Appropriation**	$	6,734,962,000	$ 7,315,857,000

Appropriations by Fund

	2024	2025
General	6,732,703,000	7,314,065,000
Health Care Access	26,000	59,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	-0-

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

Subd. 2. **Central Office; Operations**	15,739,000	11,266,000

Base level adjustment. The general fund base is $5,165,000 in fiscal year 2026 and $5,015,000 in fiscal year 2027.

Subd. 3. **Central Office; Health Care**	3,513,000	4,302,000

Base level adjustment. The general fund base is $4,032,000 in fiscal year 2026 and $4,032,000 in fiscal year 2027.

Subd. 4. **Central Office; Aging and Disabilities Services**	17,221,000	21,454,000

(a) **Research on access to long-term care services and financing.** $700,000 in fiscal year 2024 is from the general fund for

additional funding for the actuarial research study of public and private financing options for long-term services and supports reform under Laws 2021, First Special Session chapter 7, article 17, section 16. This is a onetime appropriation.

(b) **Case management training curriculum.** $377,000 in fiscal year 2024 and $377,000 fiscal year 2025 are to develop and implement a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for individuals who use home and community-based disability services and live in own-home settings. This is a onetime appropriation.

(c) **Office of ombudsman for long-term care.** $1,744,000 in fiscal year 2024 and $2,049,000 in fiscal year 2025 are for additional staff and associated direct costs in the Office of Ombudsman for Long-Term Care. The additional staff must include ten full-time regional ombudsmen, two full-time supervisors, and five additional full-time support staff.

(d) **Direct care services corps pilot project.** $500,000 in fiscal year 2024 is from the general fund for a grant to the Metropolitan Center for Independent Living for the direct care services corps pilot project. Up to $25,000 may be used by the Metropolitan Center for Independent Living for administrative costs. This is a onetime appropriation.

(e) **Base level adjustment.** The general fund base is $7,468,000 in fiscal year 2026 and $7,465,000 in fiscal year 2027.

Subd. 5. **Central Office; Behavioral Health, Housing, and Deaf and Hard of Hearing Services** 4,857,000 6,539,000

(a) **Competency-based training funding for substance use disorder provider community.** $150,000 in fiscal year 2024 and $150,000 in fiscal year 2025 are from the general fund to provide funding for provider participation in clinical training for the transition to American Society of Addiction Medicine standards.

(b) **Public awareness campaign.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund for a public awareness campaign under Minnesota Statutes, section 245.89.

(c) **Bad batch overdose surge text alert system.** $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are from the general fund for a overdose surge alert system under Minnesota Statutes, section 245.891.

(d) **Base level adjustment.** The general fund base is $4,029,000 in fiscal year 2026 and $4,029,000 in fiscal year 2027.

Subd. 6. **Forecasted Programs; Housing Support** 305,000 666,000

Subd. 7. **Forecasted Programs; MinnesotaCare** 26,000 59,000

This appropriation is from the Health Care Access Fund.

Subd. 8. **Forecasted Programs; Medical Assistance** 5,714,700,000 6,360,965,000

Subd. 9. **Forecasted Programs; Alternative Care** 47,189,000 51,046,000

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 10. **Forecasted Programs; Behavioral Health Fund**	96,387,000	98,417,000
Subd. 11. **Grant Programs; Other Long-Term Care Grants**	31,073,000	27,001,000

(a) **Provider capacity grant for rural and underserved communities.** $455,000 in fiscal year 2024 and $15,492,000 in fiscal year 2025 are for provider capacity grants for rural and underserved communities under Minnesota Statutes, section 256.4761. Of this amount, $13,016,000 in fiscal year 2025 is for grants, and $455,000 in fiscal year 2024 and $2,476,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027.

(b) **Long-term care workforce grants for new Americans.** $10,886,000 in fiscal year 2024 and $10,886,000 in fiscal year 2025 are for long-term care workforce grants for new Americans under Minnesota Statutes, section 256.4762. Of this amount, $10,060,000 in fiscal year 2024 and $10,060,000 in fiscal year 2025 are for grants to counties, and $826,000 in fiscal year 2024 and $826,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027.

(c) **Supported decision making grants.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for supported decision

making grants under Minnesota Statutes, section 256.4771.

(d) **Base level adjustment.** The general fund base is $1,925,000 in fiscal year 2026 and $1,925,000 in fiscal year 2027.

Subd. 12. **Grant Programs; Aging and Adult Services Grants** 100,027,000 105,417,000

(a) **Vulnerable Adult Act redesign phase two.** $30,101,000 in fiscal year 2024 and $28,700,000 in fiscal year 2025 are for the Vulnerable Adult Act redesign phase two. Of this amount, $19,791,000 in fiscal year 2024 and $20,652,000 in fiscal year 2025 are for grants to counties, and $10,310,000 in fiscal year 2024 and $8,048,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027.

(b) **Caregiver respite services grants.** $304,000 in fiscal year 2024 and $6,936,000 in fiscal year 2025 are for caregiver respite services grants under Minnesota Statutes, section 256.9756. $6,009,000 in fiscal year 2025 is for grants, and $304,000 in fiscal year 2024 and $927,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(c) **Live well at home grants.** $30,000,000 in fiscal year 2024 and $30,000,000 in fiscal year 2025 are for live well at home grants under Minnesota Statutes, section 256.9754, subdivision 3f. This is a onetime appropriation and is available until June 30, 2027.

(d) **Senior nutrition program.** $16,098,000 in fiscal year 2024 and $16,351,000 in fiscal year 2025 are for the senior nutrition program. $16,000,000 in fiscal year 2024 and $16,000,000 in fiscal year 2025 are for grants, and $307,000 in fiscal year 2024 and $351,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(e) **Boundary Waters Care Center.** $250,000 in fiscal year 2024 is for a sole source grant to Boundary Waters Care Center in Ely, Minnesota.

(f) **Base level adjustment.** The general fund base is $32,995,000 in fiscal year 2026 and $32,995,000 in fiscal year 2027.

Subd. 13. **Deaf and Hard of Hearing Grants**	2,886,000	2,886,000
Subd. 14. **Grant Programs; Disabilities Grants**	152,294,000	42,618,000

(a) **Direct Support Connect.** The base is increased by $250,000 in fiscal year 2026 for Direct Support Connect. This is a onetime base adjustment.

(b) **Home and community-based services innovation pool.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for the home and community-based services innovation pool under Minnesota Statutes, section 256B.0921.

(c) **Emergency grants for autism spectrum disorder treatment.** $10,000,000 in fiscal year 2024 and $10,000,000 in fiscal year 2025 are for the emergency grant program for autism spectrum disorder treatment providers.

This is a onetime appropriation and is available until June 30, 2025.

(d) **Temporary grants for small customized living providers.** $650,000 in fiscal year 2024 and $650,000 in fiscal year 2025 are for grants to assist small customized living providers to transition to community residential services licensure or integrated community supports licensure. This is a onetime appropriation.

(e) **Electronic visit verification stipends.** $6,095,000 in fiscal year 2024 is for onetime stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access the electronic visit verification system. Of this amount, $5,600,000 is for stipends and $495,000 is for administration. This is a onetime appropriation and is available until June 30, 2025.

(f) **Self-directed collective bargaining agreement; temporary rate increase memorandum of understanding.** $1,600,000 in fiscal year 2024 is for onetime stipends for individual providers covered by the SEIU collective bargaining agreement based on the memorandum of understanding related to the temporary rate increase in effect between December 1, 2020, and February 7, 2021. Of this amount, $1,400,000 of the appropriation is for stipends and $200,000 is for administration. This is a onetime appropriation.

(g) **Self-directed collective bargaining agreement; retention bonuses.** $50,750,000 in fiscal year 2024 is for onetime retention

bonuses covered by the SEIU collective bargaining agreement. Of this amount, $50,000,000 is for retention bonuses and $750,000 is for administration of the bonuses. This is a onetime appropriation and is available until June 30, 2025.

(h) **Training stipends.** $2,100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for onetime stipends of $500 for collective bargaining unit members who complete designated, voluntary trainings made available through or recommended by the State Provider Cooperation Committee. Of this amount, $2,000,000 in fiscal year 2024 is for stipends, and $100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for administration. This is a onetime appropriation.

(i) **Orientation program.** $2,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025 are for onetime $100 payments to collective bargaining unit members who complete voluntary orientation requirements. Of this amount, $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the onetime $100 payments, and $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for orientation-related costs. This is a onetime appropriation.

(j) **Home Care Orientation Trust.** $1,000,000 in fiscal year 2024 is for the Home Care Orientation Trust under Minnesota Statutes, section 179A.54, subdivision 11. The commissioner shall disburse the appropriation to the board of trustees of the Home Care Orientation Trust for deposit into an account

designated by the board of trustees outside the state treasury and state's accounting system. This is a onetime appropriation.

(k) **HIV/AIDS support services.** $10,100,000 in fiscal year 2024 is for grants to community-based HIV/AIDS support services providers and for payment of allowed health care costs as defined in Minnesota Statutes, section 256.935. This is a onetime appropriation.

(l) **Motion analysis advancements clinical study.** $400,000 is fiscal year 2024 is for a grant to the Mayo Clinic Motion Analysis Laboratory and Limb Lab for continued research in motion analysis and patient care. This is a onetime appropriation and is available through June 30, 2025.

(m) **Parent-to-parent peer support grants.** $75,000 in fiscal year 2024 and $75,000 in fiscal year 2025 are for a grant under Minnesota Statutes, section 256.4776.

(n) **Self-advocacy grants.** $323,000 in fiscal year 2024 and $323,000 in fiscal year 2025 are for self-advocacy grants under Minnesota Statutes, section 256.477. Of these amounts, $218,000 in fiscal year 2024 and $218,000 in fiscal year 2025 are for the activities under Minnesota Statutes, section 256.477, subdivision 1, paragraph (a), clauses (5) to (7), and for administrative costs, and $105,000 in fiscal year 2024 and $105,000 in fiscal year 2025 are for the activities under Minnesota Statutes, section 256.477, subdivision 2.

(o) **Home and community-based workforce incentive fund grants.** $35,641,000 in fiscal year 2024 and $4,910,000 in fiscal year 2025 are for the home and community-based workforce incentive fund grants under Minnesota Statutes, section 256.4764. The base for this appropriation is $3,151,000 in fiscal year 2026 and $2,328,000 in fiscal year 2027.

(p) **Technology grants.** $300,000 in fiscal year 2024 and $..... in fiscal year 2025 are for technology grants under Minnesota Statutes, section .....

(q) **Base level adjustment.** The general fund base is $28,359,000 in fiscal year 2026 and $27,286,000 in fiscal year 2027.

Subd. 15. **Grant Programs; Adult Mental Health Grants**	1,200,000	3,200,000

(a) **Training for peer workforce.** $1,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 from the general fund are for peer workforce training grants. This is a onetime appropriation and is available until June 30, 2027.

(b) **Family enhancement center.** $360,000 in fiscal year 2024 and $360,000 in fiscal year 2025 are for a grant to the Family Enhancement Center to develop, maintain, and expand community-based social engagement and connection programs to help families dealing with trauma and mental health issues develop connections with each other and their communities, including the NEST parent monitoring program, the cook to

connect program, and the call to movement initiative. This paragraph does not expire.

(c) **Base level adjustment.** The general fund base is $200,000 in fiscal year 2026 and $200,000 in fiscal year 2027.

Subd. 16. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	24,275,000	21,047,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	-0-

(a) **Culturally-specific recovery community organization start-up grants.** $1,141,000 in fiscal year 2024 and $3,492,000 in fiscal year 2025 are for culturally-specific recovery community organization start-up grants. $1,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are for grants, and $141,000 in fiscal year 2024 and $492,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(b) **Culturally-specific services grants.** $..... in fiscal year 2024 and $..... in fiscal year 2025 are for grants to culturally-specific providers for technical assistance navigating culturally-specific and responsive substance use and recovery programs. Of this amount, $1,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are for grants, and $..... in fiscal year 2024 and $..... in fiscal year 2025 are for administration. Notwithstanding

Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027.

(c) **Culturally-specific grant development trainings.** $..... in fiscal year 2024 and $..... in fiscal year 2025 are for grants for up to four trainings for community members and culturally-specific providers for grant writing training for substance use and recovery. Of this amount, $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for grants, and $..... in fiscal year 2024 and $..... in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(d) **Harm reduction and culturally-specific grants.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are to provide sole source grants to culturally-specific communities to purchase testing supplies and naloxone.

(e) **Families and family treatment capacity-building and start-up grants.** $10,000,000 in fiscal year 2024 is for start-up and capacity-building grants for family substance use disorder treatment programs. This is a onetime appropriation and is available until June 30, 2029.

(f) **Start-up and capacity building grants for withdrawal management.** $641,000 in fiscal year 2024 and $3,492,000 in fiscal year 2025 are for start-up and capacity building grants for withdrawal management. $500,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are for grants, and $141,000 in

fiscal year 2024 and $492,000 in fiscal year 2025 are for administration. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(g) **Recovery community organization grants.** $6,000,000 in fiscal year 2025 is for grants to recovery community organizations, as defined in Minnesota Statutes, section 254B.01, subdivision 8, to provide for costs and community-based peer recovery support services that are not otherwise eligible for reimbursement under Minnesota Statutes, section 254B.05, as part of the continuum of care for substance use disorders. Notwithstanding Minnesota Statutes, section 16A.28, this appropriation is available until June 30, 2027. This is a onetime appropriation.

(h) **Naloxone grants.** $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for naloxone grants under Minnesota Statutes, section .....

(i) **Problem gambling.** $225,000 in fiscal year 2024 and $225,000 in fiscal year 2025 are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families, and research related to problem gambling.

(j) **Project ECHO at Hennepin Health Care.** $1,228,000 in fiscal year 2024 and $1,500,000

in fiscal year 2025 are for Project ECHO grants under Minnesota Statutes, section 254B.30, subdivision 2.

(k) **White Earth Nation substance use disorder digital therapy tool.** $4,000,000 in fiscal year 2024 is appropriated from the general fund for a grant to the White Earth Nation to develop an individualized Native-American-centric digital therapy tool with Pathfinder Solutions. The grant must be used to:

(1) develop a mobile application that is culturally tailored to connecting substance use disorder resources with White Earth Nation members;

(2) convene a planning circle with White Earth Nation members to design the tool;

(3) provide and expand White Earth Nation-specific substance use disorder services; and

(4) partner with an academic research institution to evaluate the efficacy of the program.

(l) **Wellness in the Woods.** $100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for a grant to Wellness in the Woods to provide daily peer support for individuals who are in recovery, are transitioning out of incarceration, or have experienced trauma. This paragraph does not expire.

(m) **Base level adjustment.** The general fund base is $5,847,000 in fiscal year 2026 and $5,847,000 in fiscal year 2027.

Subd. 17. **Direct Care and Treatment - Transfer Authority**

Money appropriated under subdivisions 18 to 22 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

Subd. 18. **Direct Care and Treatment - Mental Health and Substance Abuse**	169,962,000	177,152,000
Subd. 19. **Direct Care and Treatment - Community-Based Services**	21,223,000	22,280,000
Subd. 20. **Direct Care and Treatment - Forensic Services**	141,020,000	148,513,000
Subd. 21. **Direct Care and Treatment - Sex Offender Program**	115,920,000	121,726,000
Subd. 22. **Direct Care and Treatment - Operations**	72,912,000	87,570,000

The general fund base is $80,222,000 in fiscal year 2026 and $81,142,000 in fiscal year 2027.

Sec. 3. **COUNCIL ON DISABILITY**	**$ 2,856,000**	**$ 3,323,000**
Sec. 4. **OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$ 3,700,000**	**$ 4,017,000**

Base level adjustment. The general fund base is $3,917,000 in fiscal year 2026 and $3,917,000 in fiscal year 2027.

Sec. 5. **COMMISSIONER OF EMPLOYMENT AND ECONOMIC DEVELOPMENT**	**$ 3,924,000**	**$ 76,000**

$3,800,000 in fiscal year 2024 is for development and implementation of an awareness-building campaign for the recruitment of direct care professionals, and $124,000 in fiscal year 2024 and $76,000 in fiscal year 2025 are for administration. This is a onetime appropriation and is available until June 30, 2025.

Sec. 6. **COMMISSIONER OF MANAGEMENT AND BUDGET** **$ 900,000 $ 900,000**

Sec. 7. Laws 2021, First Special Session chapter 7, article 16, section 28, as amended by Laws 2022, chapter 40, section 1, is amended to read:

Sec. 28. **CONTINGENT APPROPRIATIONS.**

Any appropriation in this act for a purpose included in Minnesota's initial state spending plan as described in guidance issued by the Centers for Medicare and Medicaid Services for implementation of section 9817 of the federal American Rescue Plan Act of 2021 is contingent upon the initial approval of that purpose by the Centers for Medicare and Medicaid Services, except for the rate increases specified in article 11, sections 12 and 19. This section expires June 30, 2024.

Sec. 8. **DIRECT CARE AND TREATMENT FISCAL YEAR 2023 APPROPRIATION.**

$4,829,000 is appropriated in fiscal year 2023 to the commissioner of human services for direct care and treatment programs. This is a onetime appropriation.

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

Sec. 9. **APPROPRIATION ENACTED MORE THAN ONCE.**

If an appropriation is enacted more than once in the 2023 legislative session, the appropriation must be given effect only once.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2025, unless a different expiration date is explicit.

Sec. 11. **EFFECTIVE DATE.**

This article is effective July 1, 2023, unless a different effective date is specified.

245G.05 COMPREHENSIVE ASSESSMENT AND ASSESSMENT SUMMARY.

Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an assessment summary within three calendar days from the day of service initiation for a residential program and within three calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. The comprehensive assessment summary is complete upon a qualified staff member's dated signature. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate services for the client using the dimensions in Minnesota Rules, part 9530.6622, and document the recommendations.

(b) An assessment summary must include:

(1) a risk description according to section 245G.05 for each dimension listed in paragraph (c);

(2) a narrative summary supporting the risk descriptions; and

(3) a determination of whether the client has a substance use disorder.

(c) An assessment summary must contain information relevant to treatment service planning and recorded in the dimensions in clauses (1) to (6). The license holder must consider:

(1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;

(2) Dimension 2, biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued substance use on the unborn child, if the client is pregnant;

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas and the likelihood of harm to self or others;

(4) Dimension 4, readiness for change; the support necessary to keep the client involved in treatment service;

(5) Dimension 5, relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and

(6) Dimension 6, recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

246.18 DISPOSAL OF FUNDS.

Subd. 2. **Behavioral health fund.** Money received by a substance use disorder treatment facility operated by a regional treatment center or nursing home under the jurisdiction of the commissioner of human services must be deposited in the state treasury and credited to the behavioral health fund. Money in the behavioral health fund is appropriated to the commissioner to operate substance use disorder programs.

Subd. 2a. **Disposition of interest for the behavioral health fund.** Beginning July 1, 1991, interest earned on cash balances on deposit with the commissioner of management and budget derived from receipts from substance use disorder programs affiliated with state-operated facilities under the commissioner of human services must be deposited in the state treasury and credited to a substance use disorder account under subdivision 2. Any interest earned is appropriated to the commissioner to operate substance use disorder programs according to subdivision 2.

256B.0638 OPIOID PRESCRIBING IMPROVEMENT PROGRAM.

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers.

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

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid disenrollment standards" means parameters of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider must be disenrolled as a medical assistance provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to medical assistance and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed advanced practice registered nurse actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with substance use disorder or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Advisory Council established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota;

(12) one member representing Minnesota law enforcement; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit;

(3) the medical director for the Department of Labor and Industry; and

(4) a member representing the Minnesota Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs within the Minnesota health care program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

256B.0759 SUBSTANCE USE DISORDER DEMONSTRATION PROJECT.

Subd. 6. **Medium intensity residential program participation.** Medium intensity residential programs that qualify to participate in the demonstration project shall use the specified base payment rate of $132.90 per day, and shall be eligible for the rate increases specified in subdivision 4.

256B.0917 HOME AND COMMUNITY-BASED SERVICES FOR OLDER ADULTS.

Subd. 1a. **Home and community-based services for older adults.** (a) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older adults including statewide capacity for local service development and technical assistance, and statewide availability of home and community-based services for older adult services, caregiver support and respite care services, and other supports in the state of Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

(1) reach older adults early in the progression of their need for long-term services and supports, providing them with low-cost, high-impact services that will prevent or delay the use of more costly services;

(2) support older adults to live in the most integrated, least restrictive community setting;

(3) support the informal caregivers of older adults;

(4) develop and implement strategies to integrate long-term services and supports with health care services, in order to improve the quality of care and enhance the quality of life of older adults and their informal caregivers;

(5) ensure cost-effective use of financial and human resources;

(6) build community-based approaches and community commitment to delivering long-term services and supports for older adults in their own homes;

(7) achieve a broad awareness and use of lower-cost in-home services as an alternative to nursing homes and other residential services;

(8) strengthen and develop additional home and community-based services and alternatives to nursing homes and other residential services; and

(9) strengthen programs that use volunteers.

(b) The services provided by these projects are available to older adults who are eligible for medical assistance and the elderly waiver under chapter 256S, the alternative care program under section 256B.0913, or essential community supports grant under section 256B.0922, and to persons who have their own funds to pay for services.

Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner shall establish projects to expand the availability of caregiver support and respite care services for family and other caregivers. The commissioner shall use a request for proposals to select nonprofit entities to administer the projects. Projects shall:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite care services to caregivers of older adults;

(3) assure the health and safety of the older adults;

(4) identify at-risk caregivers;

(5) provide information, education, and training for caregivers in the designated community; and

(6) demonstrate the need in the proposed service area particularly where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. Preference must be given for projects that reach underserved populations.

(b) Projects must clearly describe:

(1) how they will achieve their purpose;

(2) the process for recruiting, training, and retraining volunteers; and

(3) a plan to promote the project in the designated community, including outreach to persons needing the services.

(c) Funds for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) provide information, training, and education to caregivers;

(4) advertise the availability of the caregiver support and respite care project; and

(5) purchase equipment to maintain a system of assigning workers to clients.

(d) Project funds may not be used to supplant existing funding sources.

Subd. 7a. **Core home and community-based services.** The commissioner shall select and contract with core home and community-based services providers for projects to provide services and supports to older adults both with and without family and other informal caregivers using a request for proposals process. Projects must:

(1) have a credible, public, or private nonprofit sponsor providing ongoing financial support;

(2) have a specific, clearly defined geographic service area;

(3) use a practice framework designed to identify high-risk older adults and help them take action to better manage their chronic conditions and maintain their community living;

(4) have a team approach to coordination and care, ensuring that the older adult participants, their families, and the formal and informal providers are all part of planning and providing services;

(5) provide information, support services, homemaking services, counseling, and training for the older adults and family caregivers;

(6) encourage service area or neighborhood residents and local organizations to collaborate in meeting the needs of older adults in their geographic service areas;

(7) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to older adults and their caregivers; and

(8) provide coordination and management of formal and informal services to older adults and their families using less expensive alternatives.

Subd. 13. **Community service grants.** The commissioner shall award contracts for grants to public and private nonprofit agencies to establish services that strengthen a community's ability to provide a system of home and community-based services for elderly persons. The commissioner shall use a request for proposal process. The commissioner shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or to areas with service needs identified under section 144A.351.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 9a. **Respite services; component values and calculation of payment rates.** (a) For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for respite services are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;

(2) determine the appropriate hourly staff wage rates derived by the commissioner as provided in subdivisions 5 and 5a;

(3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the product of one plus the competitive workforce factor;

(4) for a recipient requiring deaf and hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (3);

(5) multiply the number of direct staffing hours by the appropriate staff wage;

(6) multiply the number of direct staffing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing rate;

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio;

(9) this is the subtotal rate;

(10) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(11) divide the result of clause (9) by one minus the result of clause (10). This is the total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed three; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

256S.19 MONTHLY CASE MIX BUDGET CAPS; NURSING FACILITY RESIDENTS.

Subd. 4. **Calculation of monthly conversion budget cap with consumer-directed community supports.** For the elderly waiver monthly conversion budget cap for the cost of elderly waiver services with consumer-directed community supports, the nursing facility case mix adjusted total payment rate used under subdivision 3 to calculate the monthly conversion budget cap for elderly waiver services without consumer-directed community supports must be reduced by a percentage equal to the percentage difference between the consumer-directed community supports budget limit that would be assigned according to the elderly waiver plan and the corresponding monthly case mix budget cap under this chapter, but not to exceed 50 percent.