State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 4576

03/24/2022 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to state government; modifying provisions governing the opioid crisis response, health care, and health insurance access; making forecast adjustments; requiring reports; transferring money; making technical and conforming changes; allocating funds for a specific purpose; establishing certain grants; appropriating money; amending Minnesota Statutes 2020, sections 256.042, subdivisions 1, 2, 5; 256B.055, subdivision 17; 256B.056, subdivisions 3, 7; 256B.0625, subdivisions 28b, 64; 256B.76, subdivision 1; 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision; 256L.07, subdivision 1; Minnesota Statutes 2021 Supplement, sections 256.042, subdivision 4; 256B.0625, subdivision 30; 256L.07, subdivision 2; 256L.15, subdivision 2; Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended; Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended; Laws 2021, First Special Session chapter 7, article 1, section 36; article 16, sections 2, subdivisions 29, 31, 33; 28; article 17, sections 3; 6; 10; 11; 12; 17, subdivision 3; proposing coding for new law in Minnesota Statutes, chapters 256B; 256L.

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

ARTICLE 1

OPIOID CRISIS RESPONSE

Section 1. Minnesota Statutes 2020, section 256.042, subdivision 1, is amended to read:

Subdivision 1. **Establishment of the advisory council.** (a) The Opiate Epidemic Response Advisory Council is established to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council shall focus on:

(1) prevention and education, including public education and awareness for adults and youth, prescriber education, the development and sustainability of opioid overdose prevention and education programs, the role of adult protective services in prevention and response,

and providing financial support to local law enforcement agencies for opiate antagonist programs;

(2) training on the treatment of opioid addiction, including the use of all Food and Drug Administration approved opioid addiction medications, detoxification, relapse prevention, patient assessment, individual treatment planning, counseling, recovery supports, diversion control, and other best practices;

(3) the expansion and enhancement of a continuum of care for opioid-related substance use disorders, including primary prevention, early intervention, treatment, recovery, and aftercare services; and

(4) the development of measures to assess and protect the ability of cancer patients and survivors, persons battling life-threatening illnesses, persons suffering from severe chronic pain, and persons at the end stages of life, who legitimately need prescription pain medications, to maintain their quality of life by accessing these pain medications without facing unnecessary barriers. The measures must also address the needs of individuals described in this clause who are elderly or who reside in underserved or rural areas of the state.

(b) The council shall:

(1) review local, state, and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid use disorder;

(2) establish priorities to address the state's opioid epidemic, for the purpose of recommending initiatives to fund;

(3) recommend to the commissioner of human services specific projects and initiatives to be funded;

(4) ensure that available funding is allocated to align with other state and federal funding, to achieve the greatest impact and ensure a coordinated state effort;

(5) consult with the commissioners of human services, health, and management and budget to develop measurable outcomes to determine the effectiveness of funds allocated; ~~and~~

(6) develop recommendations for an administrative and organizational framework for the allocation, on a sustainable and ongoing basis, of any money deposited into the separate account under section 16A.151, subdivision 2, paragraph (f), in order to address the opioid

abuse and overdose epidemic in Minnesota and the areas of focus specified in paragraph (a).;

(7) review reports, data, and performance measures submitted by municipalities, as defined in section 466.01, subdivision 1, in receipt of direct payments from settlement agreements, as described in section 256.043, subdivision 4; and

(8) consult with relevant stakeholders, including lead agencies and municipalities, to review and provide recommendations for necessary revisions to required reporting to ensure the reporting reflects measures of progress in addressing the harms of the opioid epidemic.

(c) The council, in consultation with the commissioner of management and budget, and within available appropriations, shall select from the awarded grants projects or may select municipality projects funded by settlement monies as described in section 256.043, subdivision 4, that include promising practices or theory-based activities for which the commissioner of management and budget shall conduct evaluations using experimental or quasi-experimental design. Grants awarded to proposals or municipality projects funded by settlement monies that include promising practices or theory-based activities and that are selected for an evaluation shall be administered to support the experimental or quasi-experimental evaluation and require grantees and municipality projects to collect and report information that is needed to complete the evaluation. The commissioner of management and budget, under section 15.08, may obtain additional relevant data to support the experimental or quasi-experimental evaluation studies. For the purposes of this paragraph, "municipality" has the meaning given in section 466.01, subdivision 1.

(d) The council, in consultation with the commissioners of human services, health, public safety, and management and budget, shall establish goals related to addressing the opioid epidemic and determine a baseline against which progress shall be monitored and set measurable outcomes, including benchmarks. The goals established must include goals for prevention and public health, access to treatment, and multigenerational impacts. The council shall use existing measures and data collection systems to determine baseline data against which progress shall be measured. The council shall include the proposed goals, the measurable outcomes, and proposed benchmarks to meet these goals in its initial report to the legislature under subdivision 5, paragraph (a), due January 31, 2021.

Sec. 2. Minnesota Statutes 2020, section 256.042, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The council shall consist of the following ~~19~~ 30 voting members, appointed by the commissioner of human services except as otherwise specified, and three nonvoting members:

(1) two members of the house of representatives, appointed in the following sequence: the first from the majority party appointed by the speaker of the house and the second from the minority party appointed by the minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area, and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(2) two members of the senate, appointed in the following sequence: the first from the majority party appointed by the senate majority leader and the second from the minority party appointed by the senate minority leader. Of these two members, one member must represent a district outside of the seven-county metropolitan area and one member must represent a district that includes the seven-county metropolitan area. The appointment by the minority leader must ensure that this requirement for geographic diversity in appointments is met;

(3) one member appointed by the Board of Pharmacy;

(4) one member who is a physician appointed by the Minnesota Medical Association;

(5) one member representing opioid treatment programs, sober living programs, or substance use disorder programs licensed under chapter 245G;

(6) one member appointed by the Minnesota Society of Addiction Medicine who is an addiction psychiatrist;

(7) one member representing professionals providing alternative pain management therapies, including, but not limited to, acupuncture, chiropractic, or massage therapy;

(8) one member representing nonprofit organizations conducting initiatives to address the opioid epidemic, with the commissioner's initial appointment being a member representing the Steve Rummler Hope Network, and subsequent appointments representing this or other organizations;

(9) one member appointed by the Minnesota Ambulance Association who is serving with an ambulance service as an emergency medical technician, advanced emergency medical technician, or paramedic;

(10) one member representing the Minnesota courts who is a judge or law enforcement officer;

(11) one public member who is a Minnesota resident and who is in opioid addiction recovery;

(12) ~~two~~ 11 members representing Indian tribes, one representing ~~the Ojibwe tribes and one representing the Dakota tribes~~ each of Minnesota's Tribal Nations;

(13) two members representing the urban American Indian population;

~~(13)~~ (14) one public member who is a Minnesota resident and who is suffering from chronic pain, intractable pain, or a rare disease or condition;

~~(14)~~ (15) one mental health advocate representing persons with mental illness;

~~(15)~~ (16) one member appointed by the Minnesota Hospital Association;

~~(16)~~ (17) one member representing a local health department; and

~~(17)~~ (18) the commissioners of human services, health, and corrections, or their designees, who shall be ex officio nonvoting members of the council.

(b) The commissioner of human services shall coordinate the commissioner's appointments to provide geographic, racial, and gender diversity, and shall ensure that at least one-half of council members appointed by the commissioner reside outside of the seven-county metropolitan area and that at least one-half of the members have lived experience with opiate addiction. Of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic.

(c) The council is governed by section 15.059, except that members of the council shall serve three-year terms and shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

(d) The chair shall convene the council at least quarterly, and may convene other meetings as necessary. The chair shall convene meetings at different locations in the state to provide geographic access, and shall ensure that at least one-half of the meetings are held at locations outside of the seven-county metropolitan area.

(e) The commissioner of human services shall provide staff and administrative services for the advisory council.

(f) The council is subject to chapter 13D.

Sec. 3. Minnesota Statutes 2021 Supplement, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to

the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning March 1, 2020.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration. The commissioner must award at least 40 percent of grants to projects that include a focus on addressing the opiate crisis in Black and Indigenous communities and communities of color.

Sec. 4. Minnesota Statutes 2020, section 256.042, subdivision 5, is amended to read:

Subd. 5. **Reports.** (a) The advisory council shall report annually to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 31 of each year~~, beginning January 31, 2021~~. The report shall include information about the individual projects that receive grants, the municipality projects funded by settlement monies as described in section 256.043, subdivision 4, and the overall role of the ~~project~~ projects in addressing the opioid addiction and overdose epidemic in Minnesota. The report must describe the grantees and the activities implemented, along with measurable outcomes as determined by the council in consultation with the commissioner of human services and the commissioner of management and budget. At a minimum, the report must include information about the number of individuals who received information or treatment, the outcomes the individuals achieved, and demographic information about the individuals participating in the project; an assessment of the progress toward achieving statewide access to qualified providers and comprehensive treatment and recovery services; and an update on the evaluations implemented by the commissioner of management and budget for the promising practices and theory-based projects that receive funding.

(b) The commissioner of management and budget, in consultation with the Opiate Epidemic Response Advisory Council, shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance when an evaluation study described in subdivision 1, paragraph (c), is complete on the promising practices or theory-based projects that are selected for evaluation

activities. The report shall include demographic information; outcome information for the individuals in the program; the results for the program in promoting recovery, employment, family reunification, and reducing involvement with the criminal justice system; and other relevant outcomes determined by the commissioner of management and budget that are specific to the projects that are evaluated. The report shall include information about the ability of grant programs to be scaled to achieve the statewide results that the grant project demonstrated.

(c) The advisory council, in its annual report to the legislature under paragraph (a) due by January 31, 2024, shall include recommendations on whether the appropriations to the specified entities under Laws 2019, chapter 63, should be continued, adjusted, or discontinued; whether funding should be appropriated for other purposes related to opioid abuse prevention, education, and treatment; and on the appropriate level of funding for existing and new uses.

(d) Municipalities receiving direct payments for settlement agreements as described in section 256.043, subdivision 4, must annually report to the commissioner on how the funds were used on opioid remediation. The report must be submitted in a format prescribed by the commissioner.

The report must include data and measurable outcomes on expenditures funded with opioid settlement funds, as identified by the commissioner, including details on services drawn from the categories of approved uses, as identified in agreements between the state of Minnesota, the Association of Minnesota Counties, and the League of Minnesota Cities. Minimum reporting requirements must include:

(1) contact information;

(2) information on funded services and programs; and

(3) target populations for each funded service and program.

(e) In reporting data and outcomes under paragraph (d), municipalities should include information on the use of evidence-based and culturally relevant services, to the extent feasible.

(f) Reporting requirements for municipal projects using $25,000 or more of settlement funds in a calendar year must also include:

(1) a brief qualitative description of successes or challenges; and

(2) results using process and quality measures.

(g) For the purposes of this subdivision, "municipality" or "municipalities" has the meaning given in section 466.01, subdivision 1.

ARTICLE 2
HEALTH CARE

Section 1. Minnesota Statutes 2020, section 256B.055, subdivision 17, is amended to read:

Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age or older, and who was enrolled in medical assistance under ~~the~~ a state plan or a waiver of ~~the~~ a plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

(b) Beginning January 1, 2023, medical assistance may be paid for a person under 26 years of age who was in foster care and enrolled in another state's Medicaid program while in foster care, in accordance with Public Law 115-271, section 1002, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act.

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

Sec. 2. Minnesota Statutes 2020, 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 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~~.~~; and

(8) for individuals who were enrolled in medical assistance during the COVID-19 federal public health emergency declared by the United States Secretary of Health and Human Services and who are subject to the asset limits established by this subdivision, assets in excess of the limits shall be disregarded until 95 days after the individual's first renewal occurring after the expiration of the COVID-19 federal public health emergency declared by the United States Secretary of Health and Human Services.

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

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2020, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

(b) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance, eligibility is available for the month the change was reported and for three months prior to the month the change was reported, if the person was eligible in those prior months.

(c) Once determined eligible for medical assistance, a child under the age of 21 shall be continuously eligible for a period of up to 12 months, unless:

(1) the child reaches age 21;

(2) the child requests voluntary termination of coverage;

(3) the child ceases to be a resident of Minnesota;

(4) the child dies; or

(5) the agency determines the child's eligibility was erroneously granted due to agency error or enrollee fraud, abuse, or perjury.

EFFECTIVE DATE. This section is effective January 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. 4. Minnesota Statutes 2020, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas in order to provide direct reimbursement.

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

Sec. 5. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the

six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall seek a federal waiver, authorized under section 1115 of the Social Security Act, to obtain federal financial participation at the 100 percent federal matching percentage available to facilities of the Indian Health Service or tribal organization in accordance with section 1905(b) of the Social Security Act for expenditures made to organizations dually certified under Title V of the Indian Health Care Improvement Act, Public Law 94-437, and as a federally qualified health center under paragraph (a) that provides services to American Indian and Alaskan Native individuals eligible for services under this subdivision.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fund-raising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association

of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan

area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

(14) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2022, an enrolled Indian Health Service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. No requirements that otherwise apply to FQHCs covered in this subdivision shall apply to Tribal FQHCs enrolled under this paragraph, except those necessary to comply with federal regulations. The commissioner shall establish an alternative payment method for Tribal FQHCs enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

Subd. 64. **Investigational drugs, biological products, devices, and clinical trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do not cover ~~the costs of any services that are incidental to, associated with, or resulting from the use of~~ investigational drugs, biological products, or devices as defined in section 151.375 or any other treatment that is part of an approved clinical trial as defined in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude coverage of medically necessary services covered under this chapter that are not related to the approved clinical trial. Any items purchased or services rendered solely to satisfy data collection and analysis for a clinical trial and not for direct clinical management of the member are not covered.

Sec. 7. **[256B.161] CLIENT ERROR OVERPAYMENT.**

Subdivision 1. **Scope.** (a) Subject to federal law and regulation, when a local agency or the Department of Human Services determines a person under section 256.98, subdivision 4, is liable for recovery of medical assistance incorrectly paid as a result of client error or when a recipient or former recipient receives medical assistance while an appeal is pending pursuant to section 256.045, subdivision 10, and the recipient or former recipient is later

determined to have been ineligible for the medical assistance received or for less medical assistance than was received during the pendency of the appeal, the local agency or the Department of Human Services must:

(1) determine the eligibility months during which medical assistance was incorrectly paid;

(2) redetermine eligibility for the incorrectly paid months using department policies and procedures that were in effect during each eligibility month that was incorrectly paid; and

(3) assess an overpayment against persons liable for recovery under section 256.98, subdivision 4, for the amount of incorrectly paid medical assistance pursuant to section 256.98, subdivision 3.

(b) Notwithstanding section 256.98, subdivision 4, medical assistance incorrectly paid to a recipient as a result of client error when the recipient is under 21 years of age is not recoverable from the recipient or recipient's estate. This section does not prohibit the state agency from:

(1) receiving payment from a trust pursuant to United States Code, title 42, section 1396p(d)(4)(A) or (C), for medical assistance paid on behalf of the trust beneficiary for services received at any age; or

(2) claiming against the designated beneficiary of an Achieving a Better Life Experience (ABLE) account or the ABLE account itself pursuant to Code of Federal Regulations, title 26, section 1.529A-2(o), for the amount of the total medical assistance paid for the designated beneficiary at any age after establishment of the ABLE account.

Subd. 2. **Recovering client error overpayment.** (a) The local agency or the Department of Human Services must not attempt recovery of the overpayment amount pursuant to chapter 270A or section 256.0471 when a person liable for a client error overpayment under section 256.98, subdivision 4, voluntarily repays the overpayment amount or establishes a payment plan in writing with the local agency or the Department of Human Services to repay the overpayment amount within 90 days after receiving the overpayment notice or after resolution of a fair hearing regarding the overpayment under section 256.045, whichever is later. When a liable person agrees to a payment plan in writing with the local agency or the Department of Human Services but has not repaid any amount six months after entering the agreement, the local agency or Department of Human Services must pursue recovery under paragraph (b).

(b) If the liable person does not voluntarily repay the overpayment amount or establish a repayment agreement under paragraph (a), the local agency or the Department of Human Services must attempt recovery of the overpayment amount pursuant to chapter 270A when the overpayment amount is eligible for recovery as a public assistance debt under chapter 270A. For any overpaid amount of solely state-funded medical assistance, the local agency or the Department of Human Services must attempt recovery pursuant to section 256.0471.

Subd. 3. **Writing off client error overpayment.** A local agency or the Department of Human Services must not attempt to recover a client error overpayment of less than $350, unless the overpayment is for medical assistance received pursuant to section 256.045, subdivision 10, during the pendency of an appeal or unless the recovery is from the recipient's estate or the estate of the recipient's surviving spouse. A local agency or the Department of Human Services may write off any remaining balance of a client error overpayment when the overpayment has not been repaid five years after the effective date of the overpayment and the local agency or the Department of Human Services determines it is no longer cost effective to attempt recovery of the remaining balance.

Sec. 8. Minnesota Statutes 2020, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients, and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on

December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,

rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by 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) Any ratables effective before July 1, 2015, do not apply to early intensive developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

(i) Medical assistance may reimburse for the cost incurred to pay the Department of Health for metabolic disorder testing of newborns who are medical assistance recipients when the sample is collected outside of an inpatient hospital setting or freestanding birth center setting because the newborn was born outside of a hospital or freestanding birth center or because it is not medically appropriate to collect the sample during the inpatient stay for the birth.

Sec. 9. Minnesota Statutes 2020, section 256L.04, subdivision 10, is amended to read:

Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to citizens or nationals of the United States and lawfully present noncitizens as defined in Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the exception of children under age 19, are ineligible for MinnesotaCare. For purposes of this subdivision, an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the United States Citizenship and Immigration Services. Families with children who are citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) Notwithstanding subdivisions 1 and 7, eligible persons include families and individuals who are lawfully present and ineligible for medical assistance by reason of immigration status and who have incomes equal to or less than 200 percent of federal poverty guidelines.

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

Sec. 10. **[256L.181] CLIENT ERROR OVERPAYMENT.**

Subdivision 1. **Scope.** (a) Subject to federal law and regulation, when a local agency or the Department of Human Services determines a person under section 256.98, subdivision 4, is liable for recovery of medical assistance incorrectly paid as a result of client error or when a recipient or former recipient receives medical assistance while an appeal is pending pursuant to section 256.045, subdivision 10, and the recipient or former recipient is later determined to have been ineligible for the medical assistance received or for less medical assistance than was received during the pendency of the appeal, the local agency or the Department of Human Services must:

(1) determine the eligibility months during which medical assistance was incorrectly paid;

(2) redetermine eligibility for the incorrectly paid months using department policies and procedures that were in effect during each eligibility month that was incorrectly paid; and

(3) assess an overpayment against persons liable for recovery under section 256.98, subdivision 4, for the amount of incorrectly paid medical assistance pursuant to section 256.98, subdivision 3.

(b) Notwithstanding section 256.98, subdivision 4, medical assistance incorrectly paid to a recipient as a result of client error when the recipient is under 21 years of age is not recoverable from the recipient or recipient's estate. This section does not prohibit the state agency from:

(1) receiving payment from a trust pursuant to United States Code, title 42, section 1396p(d)(4)(A) or (C), for medical assistance paid on behalf of the trust beneficiary for services received at any age; or

(2) claiming against the designated beneficiary of an Achieving a Better Life Experience (ABLE) account or the ABLE account itself pursuant to Code of Federal Regulations, title 26, section 1.529A-2(o), for the amount of the total medical assistance paid for the designated beneficiary at any age after establishment of the ABLE account.

Subd. 2. **Recovering client error overpayment.** (a) The local agency or the Department of Human Services must not attempt recovery of the overpayment amount pursuant to chapter 270A or section 256.0471 when a person liable for a client error overpayment under section 256.98, subdivision 4, voluntarily repays the overpayment amount or establishes a payment plan in writing with the local agency or the Department of Human Services to repay the overpayment amount within 90 days after receiving the overpayment notice or

after resolution of a fair hearing regarding the overpayment under section 256.045, whichever is later. When a liable person agrees to a payment plan in writing with the local agency or the Department of Human Services but has not repaid any amount six months after entering the agreement, the local agency or Department of Human Services must pursue recovery under paragraph (b).

(b) If the liable person does not voluntarily repay the overpayment amount or establish a repayment agreement under paragraph (a), the local agency or the Department of Human Services must attempt recovery of the overpayment amount pursuant to chapter 270A when the overpayment amount is eligible for recovery as a public assistance debt under chapter 270A. For any overpaid amount of solely state-funded medical assistance, the local agency or the Department of Human Services must attempt recovery pursuant to section 256.0471.

Subd. 3. **Writing off client error overpayment.** A local agency or the Department of Human Services must not attempt to recover a client error overpayment of less than $350, unless the overpayment is for medical assistance received pursuant to section 256.045, subdivision 10, during the pendency of an appeal or unless the recovery is from the recipient's estate or the estate of the recipient's surviving spouse. A local agency or the Department of Human Services may write off any remaining balance of a client error overpayment when the overpayment has not been repaid five years after the effective date of the overpayment and the local agency or the Department of Human Services determines it is no longer cost effective to attempt recovery of the remaining balance.

Sec. 11. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by Laws 2015, First Special Session chapter 6, section 1, is amended to read:

Subd. 5. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **Support Services Grants**

	Appropriations by Fund	
General	13,133,000	8,715,000
Federal TANF	96,311,000	96,311,000

(b) **Basic Sliding Fee Child Care Assistance Grants** 48,439,000 51,559,000

Basic Sliding Fee Waiting List Allocation.

Notwithstanding Minnesota Statutes, section

119B.03, $5,413,000 in fiscal year 2016 is to reduce the basic sliding fee program waiting list as follows:

(1) The calendar year 2016 allocation shall be increased to serve families on the waiting list. To receive funds appropriated for this purpose, a county must have:

(i) a waiting list in the most recent published waiting list month;

(ii) an average of at least ten families on the most recent six months of published waiting list; and

(iii) total expenditures in calendar year 2014 that met or exceeded 80 percent of the county's available final allocation.

(2) Funds shall be distributed proportionately based on the average of the most recent six months of published waiting lists to counties that meet the criteria in clause (1).

(3) Allocations in calendar years 2017 and beyond shall be calculated using the allocation formula in Minnesota Statutes, section 119B.03.

(4) The guaranteed floor for calendar year 2017 shall be based on the revised calendar year 2016 allocation.

Base Level Adjustment. The general fund base is increased by $810,000 in fiscal year 2018 and increased by $821,000 in fiscal year 2019.

(c) **Child Care Development Grants**	1,737,000	1,737,000
(d) **Child Support Enforcement Grants**	50,000	50,000
(e) **Children's Services Grants**		

Appropriations by Fund		
General	39,015,000	38,665,000
Federal TANF	140,000	140,000

Safe Place for Newborns. $350,000 from the general fund in fiscal year 2016 is to distribute information on the Safe Place for Newborns law in Minnesota to increase public awareness of the law. This is a onetime appropriation.

Child Protection. $23,350,000 in fiscal year 2016 and $23,350,000 in fiscal year 2017 are to address child protection staffing and services under Minnesota Statutes, section 256M.41. $1,650,000 in fiscal year 2016 and $1,650,000 in fiscal year 2017 are for child protection grants to address child welfare disparities under Minnesota Statutes, section 256E.28.

Title IV-E Adoption Assistance. Additional federal reimbursement to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for title IV-E adoption assistance is appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2016 and 2017 for adoption incentive grants are appropriated to the commissioner for postadoption services, including a parent-to-parent support network.

(f) **Children and Community Service Grants**	56,301,000	56,301,000
(g) **Children and Economic Support Grants**	26,778,000	26,966,000

Mobile Food Shelf Grants. (a) $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are for a grant to Hunger Solutions. This is a onetime appropriation and is available until June 30, 2017.

(b) Hunger Solutions shall award grants of up to $75,000 on a competitive basis. Grant applications must include:

(1) the location of the project;

(2) a description of the mobile program, including size and scope;

(3) evidence regarding the unserved or underserved nature of the community in which the project is to be located;

(4) evidence of community support for the project;

(5) the total cost of the project;

(6) the amount of the grant request and how funds will be used;

(7) sources of funding or in-kind contributions for the project that will supplement any grant award;

(8) a commitment to mobile programs by the applicant and an ongoing commitment to maintain the mobile program; and

(9) any additional information requested by Hunger Solutions.

(c) Priority may be given to applicants who:

(1) serve underserved areas;

(2) create a new or expand an existing mobile program;

(3) serve areas where a high amount of need is identified;

(4) provide evidence of strong support for the project from citizens and other institutions in the community;

(5) leverage funding for the project from other private and public sources; and

(6) commit to maintaining the program on a multilayer basis.

Homeless Youth Act. At least $500,000 of the appropriation for the Homeless Youth Act must be awarded to providers in greater Minnesota, with at least 25 percent of this amount for new applicant providers. The commissioner shall provide outreach and technical assistance to greater Minnesota providers and new providers to encourage responding to the request for proposals.

Stearns County Veterans Housing. $85,000 in fiscal year 2016 and $85,000 in fiscal year 2017 are for a grant to Stearns County to provide administrative funding in support of a service provider serving veterans in Stearns County. The administrative funding grant may be used to support group residential housing services, corrections-related services, veteran services, and other social services related to the service provider serving veterans in Stearns County.

Safe Harbor. $800,000 in fiscal year 2016 and $800,000 in fiscal year 2017 are from the general fund for emergency shelter and transitional and long-term housing beds for sexually exploited youth and youth at risk of

sexual exploitation. Of this appropriation, $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are from the general fund for statewide youth outreach workers connecting sexually exploited youth and youth at risk of sexual exploitation with shelter and services.

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2016 do not cancel but are available for this purpose in fiscal year 2017.

Base Level Adjustment. The general fund base is decreased by $816,000 in fiscal year 2018 and is decreased by $606,000 in fiscal year 2019.

(h) **Health Care Grants**

Appropriations by Fund		
General	536,000	2,482,000
Health Care Access	3,341,000	3,465,000

Grants for Periodic Data Matching for Medical Assistance and MinnesotaCare. Of the general fund appropriation, $26,000 in fiscal year 2016 and $1,276,000 in fiscal year 2017 are for grants to counties for costs related to periodic data matching for medical assistance and MinnesotaCare recipients under Minnesota Statutes, section 256B.0561. The commissioner must distribute these grants to counties in proportion to each county's number of cases in the prior year in the affected programs.

Base Level Adjustment. The general fund base is ~~increased by $1,637,000 in fiscal year 2018 and increased by $1,229,000 in fiscal~~

~~year 2019~~ maintained in fiscal years 2020 and 2021.

(i) **Other Long-Term Care Grants** 1,551,000 3,069,000

Transition Populations. $1,551,000 in fiscal year 2016 and $1,725,000 in fiscal year 2017 are for home and community-based services transition grants to assist in providing home and community-based services and treatment for transition populations under Minnesota Statutes, section 256.478.

Base Level Adjustment. The general fund base is increased by $156,000 in fiscal year 2018 and by $581,000 in fiscal year 2019.

(j) **Aging and Adult Services Grants** 28,463,000 28,162,000

Dementia Grants. $750,000 in fiscal year 2016 and $750,000 in fiscal year 2017 are for the Minnesota Board on Aging for regional and local dementia grants authorized in Minnesota Statutes, section 256.975, subdivision 11.

(k) **Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

Deaf, Deafblind, and Hard-of-Hearing Grants. $350,000 in fiscal year 2016 and $500,000 in fiscal year 2017 are for deaf and hard-of-hearing grants. The funds must be used to increase the number of deafblind Minnesotans receiving services under Minnesota Statutes, section 256C.261, and to provide linguistically and culturally appropriate mental health services to children who are deaf, deafblind, and hard-of-hearing. This is a onetime appropriation.

Base Level Adjustment. The general fund base is decreased by $500,000 in fiscal year 2018 and by $500,000 in fiscal year 2019.

(l) **Disabilities Grants** 20,820,000 20,858,000

State Quality Council. $573,000 in fiscal year 2016 and $600,000 in fiscal year 2017 are for the State Quality Council to provide technical assistance and monitoring of person-centered outcomes related to inclusive community living and employment. The funding must be used by the State Quality Council to assure a statewide plan for systems change in person-centered planning that will achieve desired outcomes including increased integrated employment and community living.

(m) **Adult Mental Health Grants**

Appropriations by Fund		
General	69,992,000	71,244,000
Health Care Access	1,575,000	2,473,000
Lottery Prize	1,733,000	1,733,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Culturally Specific Mental Health Services. $100,000 in fiscal year 2016 is for grants to nonprofit organizations to provide resources and referrals for culturally specific mental health services to Southeast Asian veterans born before 1965 who do not qualify for services available to veterans formally discharged from the United States armed forces.

Problem Gambling. $225,000 in fiscal year 2016 and $225,000 in fiscal year 2017 are from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.

Sustainability Grants. $2,125,000 in fiscal year 2016 and $2,125,000 in fiscal year 2017 are for sustainability grants under Minnesota Statutes, section 256B.0622, subdivision 11.

Beltrami County Mental Health Services Grant. $1,000,000 in fiscal year 2016 and $1,000,000 in fiscal year 2017 are from the general fund for a grant to Beltrami County to fund the planning and development of a comprehensive mental health services program under article 2, section 41, Comprehensive Mental Health Program in Beltrami County. This is a onetime appropriation.

Base Level Adjustment. The general fund base is increased by $723,000 in fiscal year 2018 and by $723,000 in fiscal year 2019. The health care access fund base is decreased by $1,723,000 in fiscal year 2018 and by $1,723,000 in fiscal year 2019.

(n) **Child Mental Health Grants** 23,386,000 24,313,000

Services and Supports for First Episode Psychosis. $177,000 in fiscal year 2017 is for grants under Minnesota Statutes, section

245.4889, to mental health providers to pilot evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis and for a public awareness campaign on the signs and symptoms of psychosis. The base for these grants is $236,000 in fiscal year 2018 and $301,000 in fiscal year 2019.

Adverse Childhood Experiences. The base for grants under Minnesota Statutes, section 245.4889, to children's mental health and family services collaboratives for adverse childhood experiences (ACEs) training grants and for an interactive Web site connection to support ACEs in Minnesota is $363,000 in fiscal year 2018 and $363,000 in fiscal year 2019.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Level Adjustment. The general fund base is increased by $422,000 in fiscal year 2018 and is increased by $487,000 in fiscal year 2019.

(o) **Chemical Dependency Treatment Support Grants**	1,561,000	1,561,000

Chemical Dependency Prevention. $150,000 in fiscal year 2016 and $150,000 in fiscal year 2017 are for grants to nonprofit organizations to provide chemical dependency prevention programs in secondary schools. When making grants, the commissioner must consider the expertise, prior experience, and outcomes

achieved by applicants that have provided prevention programming in secondary education environments. An applicant for the grant funds must provide verification to the commissioner that the applicant has available and will contribute sufficient funds to match the grant given by the commissioner. This is a onetime appropriation.

Fetal Alcohol Syndrome Grants. $250,000 in fiscal year 2016 and $250,000 in fiscal year 2017 are for grants to be administered by the Minnesota Organization on Fetal Alcohol Syndrome to provide comprehensive, gender-specific services to pregnant and parenting women suspected of or known to use or abuse alcohol or other drugs. This appropriation is for grants to no fewer than three eligible recipients. Minnesota Organization on Fetal Alcohol Syndrome must report to the commissioner of human services annually by January 15 on the grants funded by this appropriation. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born.

Base Level Adjustment. The general fund base is decreased by $150,000 in fiscal year 2018 and by $150,000 in fiscal year 2019.

Sec. 12. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

Subdivision 1. **Waivers and modifications; federal funding extension.** When the peacetime emergency declared by the governor in response to the COVID-19 outbreak expires, is terminated, or is rescinded by the proper authority, the following waivers and

modifications to human services programs issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12 that are required to comply with federal law may remain in effect for the time period set out in applicable federal law or for the time period set out in any applicable federally approved waiver or state plan amendment, whichever is later:

(1) CV15: allowing telephone or video visits for waiver programs;

(2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare as needed to comply with federal guidance from the Centers for Medicare and Medicaid Services, and until the enrollee's first renewal following the resumption of medical assistance and MinnesotaCare renewals after the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services;

(3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

(5) CV24: allowing telephone or video use for targeted case management visits;

(6) CV30: expanding telemedicine in health care, mental health, and substance use disorder settings;

(7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance Program;

(10) CV43: expanding remote home and community-based waiver services;

(11) CV44: allowing remote delivery of adult day services;

(12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance Program;

(13) CV60: modifying eligibility period for the federally funded Refugee Social Services Program; and

(14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and Minnesota Family Investment Program maximum food benefits.

Sec. 13. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to read:

Sec. 36. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

(a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06, subdivision 3, or any other provision to the contrary, the commissioner shall not collect any unpaid premium for a coverage month ~~that occurred during~~ until the enrollee's first renewal after the resumption of medical assistance renewals following the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(b) Notwithstanding any provision to the contrary, periodic data matching under Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12 months following the ~~last day of~~ resumption of medical assistance and MinnesotaCare renewals after the end of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(c) Notwithstanding any provision to the contrary, the requirement for the commissioner of human services to issue an annual report on periodic data matching under Minnesota Statutes, section 256B.0561, is suspended for one year following the last day of the COVID-19 public health emergency declared by the United States Secretary of Health and Human Services.

(d) The commissioner of human services shall take necessary actions to comply with federal guidance pertaining to the appropriate redetermination of medical assistance enrollee eligibility following the end of the public health emergency and may waive currently existing Minnesota statutes to the minimum level necessary to achieve federal compliance. All changes implemented shall be reported to the chairs and ranking minority members of the legislative committees with jurisdiction over human services within 90 days.

ARTICLE 3
HEALTH INSURANCE ACCESS

Section 1. Minnesota Statutes 2020, section 256L.04, subdivision 1c, is amended to read:

Subd. 1c. **General requirements.** (a) To be eligible for MinnesotaCare, a person must meet the eligibility requirements ~~of~~ in this section.

(b) A person eligible for MinnesotaCare shall not be considered a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified

health plan with advance payment of the federal premium tax credit offered through MNsure under chapter 62V.

(c) Paragraph (b) does not apply to a person eligible for the buy-in option under subdivision 15.

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

Sec. 2. Minnesota Statutes 2020, section 256L.04, subdivision 7a, is amended to read:

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program, except as provided in subdivision 15.

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

Sec. 3. Minnesota Statutes 2020, section 256L.04, is amended by adding a subdivision to read:

Subd. 15. **Persons eligible for buy-in option.** (a) Families and individuals with income above the maximum income eligibility limit specified in subdivision 1 or 7 who meet all other MinnesotaCare eligibility requirements are eligible for the buy-in option. All other provisions of this chapter apply unless otherwise specified.

(b) Families and individuals with income within or above the maximum income eligibility limit but ineligible for MinnesotaCare solely due to access to employer-subsidized coverage under section 256L.07, subdivision 2, are eligible for the buy-in option.

(c) Families and individuals may enroll in MinnesotaCare under this subdivision only during an annual open enrollment period or special enrollment period, as designated by MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

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

Sec. 4. Minnesota Statutes 2020, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner, unless they continue MinnesotaCare enrollment through the buy-in option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month in which the commissioner sends advance notice according to Code of Federal Regulations, title 42, section 431.211, that indicates the income of a family or individual exceeds program income limits.

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

Sec. 5. Minnesota Statutes 2021 Supplement, section 256L.07, subdivision 2, is amended to read:

Subd. 2. **Must not have access to employer-subsidized minimum essential coverage.** (a) To be eligible, a family or individual must not have access to subsidized health coverage that is affordable and provides minimum value as defined in Code of Federal Regulations, title 26, section 1.36B-2.

(b) Notwithstanding paragraph (a), an individual who has access through a spouse's or parent's employer to subsidized health coverage that is deemed minimum essential coverage under Code of Federal Regulations, title 26, section 1.36B-2, is eligible for MinnesotaCare if the employee's portion of the annual premium for employee and dependent coverage exceeds the required contribution percentage, as defined for premium tax credit eligibility under United States Code, title 26, section 36B(c)(2)(C)(i)(II), as indexed according to item (iv) of that section, of the individual's household income for the coverage year.

(c) This subdivision does not apply to a family or individual who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.

(d) This subdivision does not apply to a family or individual who enrolls through the buy-in option under section 256L.04, subdivision 15.

EFFECTIVE DATE. This section is effective January 1, 2025, 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 2021 Supplement, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly individual or family income.

~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according to the premium scale specified in paragraph (d).~~

~~(c)~~ (b) Paragraph ~~(b)~~ (a) does not apply to~~:~~

~~(1)~~ children 20 years of age or younger~~; and~~.

~~(2) individuals with household incomes below 35 percent of the federal poverty guidelines.~~

~~(d) The following premium scale is established for each individual in the household who is 21 years of age or older and enrolled in MinnesotaCare:~~

~~Federal Poverty Guideline Greater than or Equal to~~	~~Less than~~	~~Individual Premium Amount~~
~~35%~~	~~55%~~	~~$4~~
~~55%~~	~~80%~~	~~$6~~
~~80%~~	~~90%~~	~~$8~~
~~90%~~	~~100%~~	~~$10~~
~~100%~~	~~110%~~	~~$12~~
~~110%~~	~~120%~~	~~$14~~
~~120%~~	~~130%~~	~~$15~~
~~130%~~	~~140%~~	~~$16~~
~~140%~~	~~150%~~	~~$25~~
~~150%~~	~~160%~~	~~$37~~
~~160%~~	~~170%~~	~~$44~~
~~170%~~	~~180%~~	~~$52~~
~~180%~~	~~190%~~	~~$61~~

~~190%~~ ~~200%~~ ~~$71~~

~~200%~~ ~~$80~~

~~(c)~~ (c) Beginning January 1, ~~2021~~ 2023, the commissioner shall continue to charge premiums in accordance with the simplified premium scale established to comply with the American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31, 2022, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The commissioner shall adjust the premium scale ~~established under paragraph (d)~~ as needed to ensure that premiums do not exceed the amount that an individual would have been required to pay if the individual was enrolled in an applicable benchmark plan in accordance with the Code of Federal Regulations, title 42, section 600.505 (a)(1).

(d) The commissioner shall establish a sliding premium scale for persons eligible through the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2025, persons eligible through the buy-in option shall pay premiums according to the premium scale established by the commissioner. Persons 20 years of age or younger are exempt from paying premiums.

EFFECTIVE DATE. This section is effective January 1, 2023, except that the sliding premium scale established under paragraph (d) is effective January 1, 2025, and is contingent upon implementation of the buy-in option established under Minnesota Statutes, section 256L.04, subdivision 15. The commissioner of human services shall notify the revisor of statutes whether the buy-in option has been established under Minnesota Statutes, section 256L.04, subdivision 15.

Sec. 7. **TRANSITION TO MINNESOTACARE BUY-IN OPTION.**

(a) The commissioner of human services shall continue to administer MinnesotaCare as a basic health program in accordance with Minnesota Statutes, section 256L.02, subdivision 5.

(b) By January 1, 2025, the commissioner of human services shall implement a buy-in option that allows individuals with income over 200 percent of the federal poverty level to be determined eligible for MinnesotaCare. Eligible individuals must still meet all other MinnesotaCare eligibility requirements. By December 15, 2023, the commissioner shall present the following to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance:

(1) an implementation plan for the MinnesotaCare buy-in under Minnesota Statutes, section 256L.04, subdivision 15; and

(2) any additional legislative changes needed for implementation.

(c) The commissioner of human services shall seek any federal waivers, approvals, and legislative changes necessary to implement a MinnesotaCare buy-in option. This includes but is not limited to any waivers, approvals, or legislative changes necessary to allow the state to:

(1) continue to receive federal basic health program payments for basic health program-eligible MinnesotaCare enrollees and to receive other federal funding for the MinnesotaCare public option; and

(2) receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with household incomes greater than 200 percent of the federal poverty guidelines would have otherwise received.

(d) In implementing this section, the commissioner of human services shall consult with the commissioner of commerce and the board of directors of MNsure, and may contract for technical and actuarial assistance.

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

ARTICLE 4
FORECAST ADJUSTMENTS

Section 1. **HUMAN SERVICES APPROPRIATION.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**

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

Subdivision 1. **Total Appropriation**	**$**	**(585,901,000)**	**$**	**182,791,000**

	Appropriations by Fund			
General Fund	(406,629,000)	185,395,000		
Health Care Access Fund	(86,146,000)	(11,799,000)		
Federal TANF	(93,126,000)	9,195,000		

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP**

	Appropriations by Fund			
General Fund	72,106,000	(14,397,000)		
Federal TANF	(93,126,000)	9,195,000		

(b) **MFIP Child Care Assistance** (103,347,000) (73,738,000)

(c) **General Assistance** (4,175,000) (1,488,000)

(d) **Minnesota Supplemental Aid** 318,000 1,613,000

(e) **Housing Support** (1,994,000) 9,257,000

(f) **Northstar Care for Children** (9,613,000) (4,865,000)

(g) **MinnesotaCare** (86,146,000) (11,799,000)

These appropriations are from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund			
General Fund	(348,364,000)	292,880,000		
Health Care Access Fund	-0-	-0-		

(i) **Alternative Care Program** -0- -0-

(j) **Behavioral Health Fund** (11,560,000) (23,867,000)

Subd. 3. **Technical Activities** -0- -0-

These appropriations are from the federal TANF fund.

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

ARTICLE 5

APPROPRIATIONS

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

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2021, First Special Session chapter 7, article 16. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2022, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2022	**2023**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 22,339,000**	**$ 481,929,000**
Appropriations by Fund		
	2022	2023
General	20,403,000	419,583,000
Health Care Access	1,963,000	61,788,000
Federal TANF	-0-	7,000
Opiate Epidemic Response	-0-	551,000
Subd. 2. **Central Office; Operations**		
Appropriations by Fund		
General	403,000	95,527,000
Health Care Access	-0-	27,816,000

(a) **Background Studies.** (1) $1,779,000 in fiscal year 2023 is to provide a credit to providers who paid for emergency background studies in NETStudy 2.0. This is a onetime appropriation.

(2) $1,851,000 in fiscal year 2023 is to fund the costs of reprocessing emergency studies conducted under interagency agreements. This is a onetime appropriation.

(b) **Supporting Drug Pricing Litigation Costs.** $228,000 in fiscal year 2022 is for costs to comply with litigation requirements related to pharmaceutical drug price litigation. This is a onetime appropriation.

(c) **Base Level Adjustment.** The general fund base is increased $12,829,000 in fiscal year 2024 and $10,227,000 in fiscal year 2025. The health care access fund base is increased $17,810,000 in fiscal year 2024 and $17,810,000 in fiscal year 2025.

Subd. 3. **Central Office; Children and Families** -0- 5,621,000

Base Level Adjustment. The general fund base is increased $6,965,000 in fiscal year 2024 and $6,680,000 in fiscal year 2025.

Subd. 4. **Central Office; Health Care**

Appropriations by Fund		
General	-0-	2,436,000
Health Care Access	-0-	4,298,000

(a) **Interactive Voice Response and Improving Access for Applications and Forms.** $1,350,000 in fiscal year 2023 is for the improvement of accessibility to Minnesota health care programs applications, forms, and other consumer support resources and services

to enrollees with limited English proficiency. This is a onetime appropriation.

(b) **Community-Driven Improvements.** $680,000 in fiscal year 2023 is for Minnesota health care program enrollee engagement activities.

(c) **Responding to COVID-19 in Minnesota Health Care Programs.** $1,000,000 in fiscal year 2023 is for contract assistance relating to the resumption of eligibility and redetermination processes in Minnesota health care programs after the expiration of the federal public health emergency. Contracts entered into under this section are for emergency acquisition and are not subject to solicitation requirements under Minnesota Statutes, section 16C.10, subdivision 2. This is a onetime appropriation. Money is available until spent.

(d) **Base Level Adjustment.** The general fund base is increased $1,666,000 in fiscal year 2024 and $1,651,000 in fiscal year 2025. The health care access fund base is increased $4,087,000 in fiscal year 2024 and $6,300,000 in fiscal year 2025.

Subd. 5. **Central Office; Community Supports**

Appropriations by Fund		
General	-0-	7,119,000
Opioid Epidemic Response	-0-	551,000

SEIU Healthcare Arbitration Award. $5,444 in fiscal year 2023 is for arbitration awards resulting from a SEIU grievance. This is a onetime appropriation.

Base Level Adjustment. The general fund base is increased $9,460,000 in fiscal year 2024 and $10,602,000 in fiscal year 2025.

Subd. 6. **Forecasted Programs; MFIP/DWP**

Appropriations by Fund		
General	-0-	5,000
Federal TANF	-0-	7,000

Subd. 7. **Forecasted Programs; MFIP Child Care Assistance** -0- 1,000

Subd. 8. **Forecasted Programs; Minnesota Supplemental Aid** -0- 1,000

Subd. 9. **Forecasted Programs; Housing Supports** -0- 1,000

Subd. 10. **Forecasted Programs; MinnesotaCare** -0- 15,257,000

This appropriation is from the health care access fund.

Subd. 11. **Forecasted Programs; Medical Assistance**

Appropriations by Fund		
General	-0-	7,571,000
Health Care Access	-0-	14,353,000

Subd. 12. **Forecasted Programs; Alternative Care** -0- 161,000

Subd. 13. **Grant Programs; BSF Child Care Grants** -0- (683,000)

Base Level Adjustment. The general fund base is increased $240,477,000 in fiscal year 2024 and $546,025,000 in fiscal year 2025.

Subd. 14. **Grant Programs; Child Care Development Grants** -0- 31,703,000

(a) **Child Care Provider Access to Technology Grants.** $300,000 in fiscal year 2023 is for child care provider access to technology grants pursuant to Minnesota Statutes, section 119B.28.

(b) **One-Stop Regional Assistance Network.** Beginning in fiscal year 2025, the base shall include $1,200,000 from the general fund for a grant to the statewide child care resource and referral network to administer the child care one-stop shop regional assistance network in accordance with Minnesota Statutes, section 119B.19, subdivision 7, clause (9).

(c) **Child Care Workforce Development Grants.** Beginning in fiscal year 2025, the base shall include $1,300,000 for a grant to the statewide child care resource and referral network to administer the child care workforce development grants in accordance with Minnesota Statutes, section 119B.19, subdivision 7, clause (10).

(d) **Shared Services Innovation Grants.** The base shall include $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 for shared services innovation grants pursuant to Minnesota Statutes, section 119B.27.

(e) **Stabilization Grants for Child Care Providers Experiencing Financial Hardship.** $31,406,000 in fiscal year 2023 is for child care stabilization grants for child care programs in extreme financial hardship. This is a onetime appropriation. Money not distributed in fiscal year 2023 or 2024 shall be available until June 30, 2025. Use of grant money must be made in accordance with eligibility and compliance requirements established by the commissioner.

(f) **Base Level Adjustment.** The general fund base is increased $66,824,000 in fiscal year 2024 and $3,300,000 in fiscal year 2025.

Subd. 15. **Grant Programs; Children's Services Grants** -0- 3,882,000

(a) **American Indian Child Welfare Initiative; Mille Lacs Band of Ojibwe Planning.** $1,263,000 in fiscal year 2023 is to support activities necessary for the Mille Lacs Band of Ojibwe to join the American Indian child welfare initiative.

(b) **Expand Parent Support Outreach Program.** The base shall include $7,000,000 in fiscal year 2024 and $7,000,000 in fiscal year 2025 to expand the parent support outreach program to community-based agencies, public health agencies, and schools to prevent reporting of and entry into the child welfare system.

(c) **Thriving Families Safer Children.** The base shall include $30,000 in fiscal year 2024 to plan for an education attendance support diversionary program to prevent entry into the child welfare system. The commissioner shall report back to the legislative committees that oversee child welfare by January 1, 2025, on the plan for this program. This is a onetime appropriation.

(d) **Family Group Decision Making.** The base shall include $5,000,000 in fiscal year 2024 and $5,000,000 in fiscal year 2025 to expand the use of family group decision making to provide opportunity for family voices concerning critical decisions in child safety and prevent entry into the child welfare system.

(e) **Child Welfare Promising Practices.** The base shall include $5,000,000 in fiscal year

2024 and $5,000,000 in fiscal year 2025 to develop promising practices for prevention of out-of-home placement of children and youth.

(f) **Family Assessment Response.** The base shall include $23,550,000 in fiscal year 2024 and $23,550,000 in fiscal year 2025 to support counties and Tribes that are members of the American Indian child welfare initiative in providing case management services and support for families being served under family assessment response, and prevent entry into the child welfare system.

(g) **Extend Support for Youth Leaving Foster Care.** $600,000 in fiscal year 2023 is to extend financial supports for young adults aging out of foster care to age 22.

(h) **Grants to Counties for Child Protection Staff.** $1,000,000 in fiscal year 2023 is to provide grants to counties and American Indian child welfare initiative Tribes to be used to reduce extended foster care caseload sizes to ten cases per worker.

(i) **Statewide Pool of Qualified Individuals.** $1,177,400 in fiscal year 2023 is for grants to one or more grantees to establish and manage a pool of state-funded qualified individuals to assess potential out-of-home placement of a child in a qualified residential treatment program. Up to $200,000 of the grants each fiscal year is available for grantee contracts to manage the state-funded pool of qualified individuals. This amount shall also pay for qualified individual training, certification, and background studies. Remaining grant money shall be used until expended to provide

qualified individual services to counties and Tribes that have joined the American Indian child welfare initiative pursuant to Minnesota Statutes, section 256.01, subdivision 14b, to provide qualified residential treatment program assessments at no cost to the county or Tribal agency.

(j) **Base Level Adjustment.** The general fund base is increased $47,440,000 in fiscal year 2024 and $44,769,000 in fiscal year 2025.

Subd. 16. **Grant Program; Refugee Services Grants** -0- 5,111,000

(a) **Refugee and Immigrant Services.** $5,111,000 in fiscal year 2023 is to extend the refugee and immigrant COVID-19 care line and expand eligibility for self-sufficiency and community integration services provided by community-based nonprofit resettlement agencies to immigrants in Minnesota.

(b) **Base Level Adjustment.** The general fund base is $5,111,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 17. **Grant Programs; Children and Community Service Grants** -0- -0-

Base Level Adjustment. The Opiate Epidemic Response Base is increased $100,000 in fiscal year 2025.

Subd. 18. **Grant Programs; Children and Economic Support Grants** -0- 89,099,000

(a) **Family and Community Resource Hubs.** $2,550,000 in fiscal year 2023 is to implement a sustainable family and community resource hub model through the community action agencies under Minnesota Statutes, section 256E.31, and federally recognized Tribes. The

community resource hubs must offer navigation to several supports and services, including but not limited to basic needs and economic assistance, disability services, healthy development and screening, developmental and behavioral concerns, family well-being and mental health, early learning and child care, dental care, legal services, and culturally specific services for American Indian families.

(b) **Tribal Food Sovereignty Infrastructure Grants.** $4,000,000 in fiscal year 2023 is for capital and infrastructure development to support food system changes and provide equitable access to existing and new methods of food support for American Indian communities, including federally recognized Tribes and American Indian nonprofit organizations. This is a onetime appropriation and is available until June 30, 2025.

(c) **Tribal Food Security.** $2,836,000 in fiscal year 2023 is to promote food security for American Indian communities, including federally recognized Tribes and American Indian nonprofit organizations. This includes hiring staff, providing culturally relevant training for building food access, purchasing technical assistance materials and supplies, and planning for sustainable food systems.

(d) **Capital for Emergency Food Distribution Facilities.** $14,931,000 in fiscal year 2023 is for improving and expanding the infrastructure of food shelf facilities across the state, including adding freezer or cooler space and dry storage space, improving the

safety and sanitation of existing food shelves, and addressing deferred maintenance or other facility needs of existing food shelves. Grant money shall be made available to nonprofit organizations, federally recognized Tribes, and local units of government. This is a onetime appropriation and is available until June 30, 2025.

(e) **Food Support Grants.** $5,000,000 in fiscal year 2023 is to provide additional resources to a diverse food support network that includes food shelves, food banks, and meal and food outreach programs. Grant money shall be made available to nonprofit organizations, federally recognized Tribes, and local units of government.

(f) **Emergency Services Grants.** $54,782,000 in fiscal year 2023 is for emergency services grants under Minnesota Statutes, section 256E.36. This is a onetime appropriation and is available until June 30, 2024. Beginning in fiscal year 2024, the base for emergency services grants under Minnesota Statutes, section 256E.36, shall be increased by $29,751,000.

(g) **Base Level Adjustment.** The general fund base is increased $60,429,000 in fiscal year 2024 and $64,079,000 in fiscal year 2025.

Subd. 19. **Grant Programs; Health Care Grants**

Appropriations by Fund		
	2022	2023
General Fund	-0-	4,500,000
Health Care Access	1,936,000	64,000

(a) **Grant Funding to Support Urban American Indians in Minnesota Health Care Programs.** $2,500,000 in fiscal year 2023 is for funding to the Indian Health Board of Minneapolis to support continued access to health care coverage through Minnesota health care programs, improve access to quality care, and increase vaccination rates among urban American Indians.

(b) **Grants for Navigator Organizations.** (1) $1,936,000 in fiscal year 2023 is from the health care access fund for grants to organizations with a MNsure grant services navigator assister contract in good standing as of June 30, 2022. The grants to each organization must be in proportion to the number of medical assistance and MinnesotaCare enrollees each organization assisted that resulted in a successful enrollment in the second quarter of fiscal year 2020, as determined by MNsure's navigator payment process. This is a onetime appropriation. Money from this appropriation is available until spent. (2) $2,000,000 in fiscal year 2023 is from the health care access fund for incentive payments as defined in Minnesota Statutes, section 256.962, subdivision 5. The general fund base for this appropriation is $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025. Money from this appropriation is available until spent.

(c) **Base level adjustment.** The general fund base is increased $3,750,000 in fiscal year 2024 and $1,250,000 in fiscal year 2025. The health care access fund base is increased

$1,000,000 in fiscal year 2024, and $0 in fiscal year 2025.

(d) **Health and Human Services Vaccination Rates.** $1,000,000 in fiscal year 2023 is for community outreach grants to increase vaccination rates among enrollees in Minnesota health care programs. This is a onetime appropriation.

Subd. 20. **Grant Programs; Other Long-Term Care Grants** -0- 118,000,000

Workforce Incentive Fund Grant Program. $118,000,000 in fiscal year 2023 is to assist disability, housing, substance use, and older adult service providers of public programs to pay for incentive benefits to current and new workers. This is a onetime appropriation and is available until June 30, 2025. Three percent of the total amount of the appropriation may be used to administer the program, which could include contracting with a third-party administrator.

Subd. 21. **Grant Programs; Disabilities Grants** -0- 8,200,000

(a) **Electronic Visit Verification (EVV) Stipends.** $6,440,000 in fiscal year 2023 is for onetime stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access EVV. $5,600,000 of the appropriation is for stipends and the remaining 15 percent is for administration of these stipends. This is a onetime appropriation.

(b) **Self-Directed Collective Bargaining Agreement; Temporary Rate Increase Memorandum of Understanding.** $1,610,000 in fiscal year 2023 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. $1,400,000 of the appropriation is for stipends and the remaining 15 percent is for administration of the stipends. This is a onetime appropriation.

(c) Base Level Adjustment. The general fund base is increased $805,000 in fiscal year 2024 and $2,420,000 in fiscal year 2025.

Subd. 22. **Grant Programs; Housing Support Grants** -0- 1,100,000

(a) **AmeriCorps Heading Home Corps.** $1,100,000 in fiscal year 2023 is for the AmeriCorps Heading Home Corps program to fund housing resource navigators supporting individuals experiencing homelessness.

(b) **Base Level Adjustment.** The general fund base is increased $1,100,000 in fiscal year 2024 and $12,100,000 in fiscal year 2025.

Subd. 23. **Grant Programs; Adult Mental Health Grants** 20,000,000 18,927,000

(a) **Inpatient Psychiatric and Psychiatric Residential Treatment Facilities.** $10,000,000 in fiscal year 2023 is for competitive grants to hospitals or mental health providers to retain, build, or expand children's inpatient psychiatric beds for children in need of acute high-level psychiatric care or psychiatric residential treatment facility beds as described in Minnesota Statutes, section 256B.0941. In order to be eligible for a grant, a hospital or mental health provider

must serve individuals covered by medical assistance under Minnesota Statutes, section 256B.0625.

(b) **Expanding Support for Psychiatric Residential Treatment Facilities.** $800,000 in fiscal year 2023 is for start-up grants to psychiatric residential treatment facilities as described in Minnesota Statutes, section 256B.0941. Grantees can use grant money for emergency workforce shortage uses. Allowable grant uses related to emergency workforce shortages may include but are not limited to hiring and retention bonuses, recruitment of a culturally responsive workforce, and allowing providers to increase the hourly rate in order to be competitive in the market.

(c) **Workforce Incentive Fund Grant Program.** $20,000,000 in fiscal year 2022 from the general fund is to provide mental health public program providers the ability to pay for incentive benefits to current and new workers. This is a onetime appropriation and is available until June 30, 2025. Three percent of the total amount of the appropriation may be used to administer the program, which could include contracting with a third-party administrator.

(d) **Cultural and Ethnic Infrastructure Grant Funding.** $5,000,000 in fiscal year 2023 is for increasing cultural and ethnic infrastructure grant funding under Minnesota Statutes, section 245.4661, subdivision 6. This grant funding will be used to alleviate the workforce shortage and will be used to recruit

more providers who are Black, Indigenous, and people of color for both mental health and substance use disorder organizations.

(e) **Mental Health Provider Grants to Rural and Underserved Communities.** $5,000,000 in fiscal year 2023 is for a grant program to recruit mental health providers in rural areas and underserved communities. This money can be used for reimbursement of supervision costs of interns and clinical trainees, reimbursing staff for master's degree tuition costs in mental health fields, and licensing and exam fees.

(f) **Culturally Specific Grants.** $2,000,000 in fiscal year 2023 and $2,000,000 in fiscal year 2024 are for grants for small to midsize nonprofit organizations who represent and support American Indian, Indigenous, and other communities disproportionately affected by the opiate crisis. These grants utilize traditional healing practices and other culturally congruent and relevant supports to prevent and curb opiate use disorders through housing, treatment, education, aftercare, and other activities as determined by the commissioner. This is a onetime appropriation.

(g) **Base Level Adjustment.** The general fund base is increased $ 23,791,000 in fiscal year 2024 and $30,916,000 in fiscal year 2025. The opiate epidemic response base is increased $2,000,000 in fiscal year 2025.

Subd. 24. **Grant Programs; Child Mental Health Grants**	-0-	10,800,000

Base Level Adjustment. The general fund base is increased $15,800,000 in fiscal year 2024 and $800,000 in fiscal year 2025.

Subd. 25. **Grant Programs; Chemical Dependency Treatment Support Grants** -0- 4,000,000

(a) **Emerging Mood Disorder Grant Program.** $1,000,000 in fiscal year 2023 is for emerging mood disorder grants under Minnesota Statutes, section 245.4904. Grantees must use grant money as required in Minnesota Statutes, section 245.4904, subdivision 2.

(b) **Substance Use Disorder Treatment and Prevention Grants.** The base shall include $4,000,000 in fiscal year 2024 and $4,000,000 in fiscal year 2025 for substance use disorder treatment and prevention grants recommended by the substance use disorder advisory council.

(c) **Traditional Healing Grants.** The base shall include $2,000,000 in fiscal year 2025 to extend the traditional healing grant funding appropriated in Laws 2019, chapter 63, article 3, section 1, paragraph (h), from the opiate epidemic response account to the commissioner of human services. This funding is awarded to all Tribal nations and to 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.

(d) **Base Level Adjustment.** The general fund base is increased $4,000,000 in fiscal year 2024 and $2,000,000 in fiscal year 2025.

Subd. 26. **Direct Care and Treatment - Operations** -0- 6,501,000

Base Level Adjustment. The general fund base is increased $5,267,000 in fiscal year 2024 and $0 in fiscal year 2025.

Subd. 27. **Technical Activities** -0- -0-

(a) **Transfers; Child Care and Development Fund.** For fiscal years 2024 and 2025, the base shall include a transfer of $23,500,000 in fiscal year 2024 and $23,500,000 in fiscal year 2025 from the TANF fund to the child care and development fund. These are onetime transfers.

(b) **Base Level Adjustment.** The TANF base is increased $23,500,000 in fiscal year 2024, $23,500,000 in fiscal year 2025, and $0 in fiscal year 2026.

Sec. 3. **BOARD OF DIRECTORS OF MNSURE**

Appropriations by Fund

	2022	2023
General	-0-	7,775,000
Health Care Access	-0-	3,500,000

These appropriations may be transferred to the MNSure account established by Minnesota Statutes, section 62V.07. The health care access fund appropriation is onetime.

Base Adjustment. The general fund base for this appropriation is $7,476,000 in fiscal year 2024, $3,521,000 in fiscal year 2025, and $0 in fiscal year 2026.

Sec. 4. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 29, is amended to read:

Subd. 29. **Grant Programs; Disabilities Grants** 31,398,000 31,010,000

(a) **Training Stipends for Direct Support Services Providers.** $1,000,000 in fiscal year

2022 is from the general fund for stipends for individual providers of direct support services as defined in Minnesota Statutes, section 256B.0711, subdivision 1. These stipends are available to individual providers who have completed designated voluntary trainings made available through the State-Provider Cooperation Committee formed by the State of Minnesota and the Service Employees International Union Healthcare Minnesota. Any unspent appropriation in fiscal year 2022 is available in fiscal year 2023. This is a onetime appropriation. This appropriation is available only if the labor agreement between the state of Minnesota and the Service Employees International Union Healthcare Minnesota under Minnesota Statutes, section 179A.54, is approved under Minnesota Statutes, section 3.855.

(b) **Parent-to-Parent Peer Support.** $125,000 in fiscal year 2022 and $125,000 in fiscal year 2023 are from the general fund for a grant to an alliance member of Parent to Parent USA to support the alliance member's parent-to-parent peer support program for families of children with a disability or special health care need.

(c) **Self-Advocacy Grants.** (1) $143,000 in fiscal year 2022 and $143,000 in fiscal year 2023 are from the general fund for a grant under Minnesota Statutes, section 256.477, subdivision 1.

(2) $105,000 in fiscal year 2022 and $105,000 in fiscal year 2023 are from the general fund

for subgrants under Minnesota Statutes, section 256.477, subdivision 2.

(d) **Minnesota Inclusion Initiative Grants.** $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are from the general fund for grants under Minnesota Statutes, section 256.4772.

(e) **Grants to Expand Access to Child Care for Children with Disabilities.** $250,000 in fiscal year 2022 and $250,000 in fiscal year 2023 are from the general fund for grants to expand access to child care for children with disabilities. Any unspent amount in fiscal year 2022 is available through June 30, 2023. This is a onetime appropriation.

(f) **Parenting with a Disability Pilot Project.** The general fund base includes $1,000,000 in fiscal year 2024 and $0 in fiscal year 2025 to implement the parenting with a disability pilot project.

(g) **Base Level Adjustment.** The general fund base is $29,260,000 in fiscal year 2024 and $22,260,000 in fiscal year 2025.

Sec. 5. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 31, is amended to read:

Subd. 31. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	98,772,000	98,703,000
Opiate Epidemic Response	2,000,000	2,000,000

(a) **Culturally and Linguistically Appropriate Services Implementation Grants.** $2,275,000 in fiscal year 2022 and

$2,206,000 in fiscal year 2023 are from the general fund for grants to disability services, mental health, and substance use disorder treatment providers to implement culturally and linguistically appropriate services standards, according to the implementation and transition plan developed by the commissioner. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $1,655,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) **Base Level Adjustment.** The general fund base is $93,295,000 in fiscal year 2024 and $83,324,000 in fiscal year 2025. The opiate epidemic response fund base is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 6. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33, is amended to read:

Subd. 33. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	4,273,000	4,274,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	500,000

(a) **Problem Gambling.** $225,000 in fiscal year 2022 and $225,000 in fiscal year 2023 are from the lottery prize fund for a grant to the 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 providing effective treatment services to

problem gamblers and their families, and research related to problem gambling.

(b) **Recovery Community Organization Grants.** $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the general fund 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. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025

(c) **Base Level Adjustment.** The general fund base is $4,636,000 in fiscal year 2024 and $2,636,000 in fiscal year 2025. The opiate epidemic response fund base is $500,000 in fiscal year 2024 and $0 in fiscal year 2025.

Sec. 7. Laws 2021, First Special Session chapter 7, article 16, section 28, 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 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. Laws 2021, First Special Session chapter 7, article 17, section 3, is amended to read:

Sec. 3. **GRANTS FOR TECHNOLOGY FOR HCBS RECIPIENTS.**

(a) This act includes $500,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to issue competitive grants to home and community-based service providers. Grants must be used to provide technology assistance, including but not limited to Internet services, to older adults and people with disabilities who do not have access to technology resources necessary to use remote service delivery and telehealth. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,500,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

Sec. 9. Laws 2021, First Special Session chapter 7, article 17, section 6, is amended to read:

Sec. 6. **TRANSITION TO COMMUNITY INITIATIVE.**

(a) This act includes $5,500,000 in fiscal year 2022 and $5,500,000 in fiscal year 2023 for additional funding for grants awarded under the transition to community initiative described in Minnesota Statutes, section 256.478. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $4,125,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This section expires June 30, 2024.

Sec. 10. Laws 2021, First Special Session chapter 7, article 17, section 10, is amended to read:

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

(a) This act includes $6,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for the commissioner to establish a grant program for small provider organizations that provide services to rural or underserved communities with limited home and

community-based services provider capacity. The grants are available to build organizational capacity to provide home and community-based services in Minnesota and to build new or expanded infrastructure to access medical assistance reimbursement. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $8,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(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 work with the commissioner of management and budget and the commissioner of the Department of Administration to mitigate barriers in accessing grant funds. Funding awarded for the community engagement activities described in this paragraph is exempt from state solicitation requirements under Minnesota Statutes, section 16B.97, for activities that occur in fiscal year 2022.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

Sec. 11. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to read:

Sec. 11. **EXPAND MOBILE CRISIS.**

(a) This act includes $8,000,000 in fiscal year 2022 and $8,000,000 in fiscal year 2023 for additional funding for grants for adult mobile crisis services under Minnesota Statutes, section 245.4661, subdivision 9, paragraph (b), clause (15). Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for this purpose is $4,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) All grant activities must be completed by March 31, 2024.

(d) This section expires June 30, 2024.

Sec. 12. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to read:

Sec. 12. **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD AND ADOLESCENT MOBILE TRANSITION UNIT.**

(a) This act includes $2,500,000 in fiscal year 2022 and $2,500,000 in fiscal year 2023 for the commissioner of human services to create children's mental health transition and support teams to facilitate transition back to the community of children from psychiatric residential treatment facilities, and child and adolescent behavioral health hospitals. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $1,875,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) Beginning April 1, 2024, counties may fund and continue conducting activities funded under this section.

(c) This section expires March 31, 2024.

Sec. 13. Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3, is amended to read:

Subd. 3. **Respite services for older adults grants.** (a) This act includes $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 for the commissioner of human services to establish a grant program for respite services for older adults. The commissioner must award grants on a competitive basis to respite service providers. Any unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund base included in this act for this purpose is $2,000,000 in fiscal year 2024 and $0 in fiscal year 2025.

(b) All grant activities must be completed by March 31, 2024.

(c) This subdivision expires June 30, 2024.