Senator ..... moves to amend S.F. No. 2934 as follows:

Page 2, after line 14, insert:

"Sec. 2. **[245.996] POSITIVE SUPPORTS PROVIDER TRAINING AND ENDORSEMENT SYSTEM.**

Subdivision 1. **Creation and purpose.** The commissioner must establish a positive supports provider training and endorsement system to train providers and to create an advanced designation status for provider organizations that demonstrate competency to deliver person-centered, positive supports strategies. For the purpose of this section, positive support strategies means a strengths-based strategy based on an individualized assessment that emphasizes teaching a person productive and self-determined skills or alternative strategies and behaviors without the use of restrictive interventions.

Subd. 2. **Eligibility.** Provider organizations that serve older adults, people with disabilities, and people with behavioral health conditions may apply for the endorsement. The commissioner may offer training and technical assistance to provider organizations that are developing capacity to meet the requirements of the endorsement status.

Subd. 3. **Access to resources.** Provider organizations that meet the endorsement requirements must be provided access to a consultative clinical panel that will provide recommendations to improve positive supports and outcomes, person-centered planning facilitators that will support transition planning, and positive supports training and technical assistance.

Subd. 4. **Evaluation.** The commissioner must collect data to evaluate the outcomes of the endorsement system, improve program design, and use implementation science to support the development of multitiered systems of positive supports within organizations, local agencies, and human service and health care continuums of care."

Page 15, line 20, before "employment" insert "informed choice, cultural competency,"

Page 15, line 21, after the period, insert "By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services."

Page 19, line 32, before "employment" insert "informed choice, cultural competency,"

Page 19, line 33, after the period, insert "By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner. For case

managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services."

Page 20, delete section 15

Page 22, after line 6, insert:

"Sec. 17. Minnesota Statutes 2022, section 256B.4911, is amended by adding a subdivision to read:

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

(1) alternative care program;

(2) brain injury waiver;

(3) community alternative care waiver;

(4) community access for disability inclusion waiver;

(5) developmental disabilities waiver;

(6) elderly waiver; and

(7) Minnesota senior health option.

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

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

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

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

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

Page 22, line 9, delete "worker" and insert "professional"

Page 24, line 27, strike "available as of December 31, 2021" and insert "published in March 2021"

Page 24, line 28, delete "2025" and insert "2026"

Page 24, line 29, strike "available 30 months and one day" and insert "published in March, two years"

Page 28, line 6, after the period, insert "The value of the competitive workforce factor may not increase by more than four percentage points following each update."

Page 29, line 1, delete "8.4" and insert "8.42"

Page 30, line 30, delete "8.4" and insert "8.42"

Page 32, line 21, delete "8.4" and insert "8.42"

Page 33, after line 27, insert:

"Sec. 29. Minnesota Statutes 2022, section 256B.4914, subdivision 10a, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

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

(d) The commissioner shall analyze cost data submitted under paragraph (a) and, in consultation with stakeholders identified in subdivision 17, may submit recommendations on component values and inflationary factor adjustments to the chairs and ranking minority members of the legislative committees with jurisdiction over human services once every four years beginning January 1, 2021. The commissioner shall make recommendations in conjunction with reports submitted to the legislature according to subdivision 10, paragraph (c). The commissioner shall release cost data in an aggregate form, and cost data from individual providers must not be released except as provided for in current law.

(e) ~~The commissioner shall release cost data in an aggregate form, and cost data from individual providers shall not be released except as provided for in current law.~~ The commissioner shall use data collected in paragraph (a) to determine the compliance with requirements identified under subdivision 10d. The commissioner shall identify providers who have not met the thresholds identified under subdivision 10d on the Department of Human Services website for the year for which the providers reported their costs.

~~(f) The commissioner, in consultation with stakeholders identified in subdivision 17, shall develop and implement a process for providing training and technical assistance~~

~~necessary to support provider submission of cost documentation required under paragraph (a).~~

EFFECTIVE DATE. This section is effective January 1, 2025.

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

Subd. 10d. **Direct care staff; compensation.** (a) A provider paid with rates determined under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates determined under that subdivision for direct care staff compensation.

(b) A provider paid with rates determined under subdivision 7 must use a minimum of 45 percent of the revenue generated by rates determined under that subdivision for direct care compensation.

(c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum of 60 percent of the revenue generated by rates determined under those subdivisions for direct care compensation.

(d) Compensation under this subdivision includes:

(1) wages;

(2) taxes and workers' compensation;

(3) health insurance;

(4) dental insurance;

(5) vision insurance;

(6) life insurance;

(7) short-term disability insurance;

(8) long-term disability insurance;

(9) retirement spending;

(10) tuition reimbursement;

(11) wellness programs;

(12) paid vacation time;

(13) paid sick time; or

(14) other items of monetary value provided to direct care staff.

EFFECTIVE DATE. This section is effective January 1, 2025."

Page 37, line 24, reinstate "personal care assistance services and CFSS:" and delete the new language and insert "88.19 percent;"

Page 37, delete line 25

Page 37, line 26, reinstate "enhanced rate personal care assistance services and enhanced rate CFSS:" and after the stricken "75.45" insert "88.19"

Page 37, line 27, reinstate the stricken language and delete the new language

Page 37, line 28, reinstate "(3) qualified professional services and CFSS worker training and development:" and after the stricken "75.45" insert "88.19"

Page 37, line 29, reinstate the stricken language

Page 37, after line 29, insert:

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

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

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

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

Page 38, line 1, delete "(c)" and insert "(d)"

Page 38, line 14, delete "(d)" and insert "(e)"

Page 38, line 19, delete "ninety" and insert "90" and delete everything after the period and insert "Paragraph (b) expires January 1, 2025, or within 90 days of federal approval of paragraph (c), whichever is later. Paragraphs (c), (d), and (e) are effective"

Page 38, line 20, delete "ninety" and insert "90"

Page 39, line 17, delete "(b)" and insert "(d)"

Page 43, line 1, delete ", clause (1),"

Page 44, after line 3, insert:

"Sec. 43. **[256S.191] ELDERLY WAIVER BUDGET AND RATE EXCEPTIONS; HIGH-NEED PARTICIPANTS.**

Subdivision 1. **Eligibility for budget and rate exceptions.** A participant is eligible to request an elderly waiver budget and rate exception when:

(1) the person is hospitalized beyond medical necessity but has been otherwise unable to be discharged to the community due to lack of community options;

(2) the person requires a support plan that exceeds elderly waiver budgets and rates due to the participant's specific assessed needs; and

(3) the person meets all eligibility criteria for the elderly waiver.

Subd. 2. **Requests for elderly waiver budget and rate exceptions.** (a) In a format prescribed by the commissioner, a participant who is eligible under subdivision 1 may request an elderly waiver budget and rate exception when requesting an eligibility determination for elderly waiver services. The request may include an exception to the elderly waiver case mix caps, an exception to the customized living service rate limits, an exception to service rates, or any combination.

(b) The request must document that the individual has needs that cannot be met within the existing case mix caps, customized living service rate limits, or service rates and must document how an exception will meet the individual's needs.

(c) The request must include the basis for the underlying costs used to determine the overall cost of the proposed service plan.

(d) Whether granted, denied, or modified, the commissioner shall respond to all exception requests. The commissioner shall include in the response the basis for the action and provide notification of the right to appeal.

(e) Individuals granted exceptions under this section shall apply annually in a format prescribed by the commissioner to continue or modify the exception.

(f) An individual no longer needs an exception when the person's needs can be met within standard program budgets and rates."

Page 45, line 30, strike "payment" and insert "rate"

Page 46, line 4, strike "and"

Page 46, line 6, strike the period and insert "; and"

Page 46, after line 6, insert:

"(5) homemaker assistance with personal care and homemaker home management under community access for disability inclusion waiver, brain injury waiver, and community alternative care waiver under section 256B.49, and developmental disabilities waiver under section 256B.092."

Page 46, after line 16, insert:

"Subd. 3. **Cost reporting.** (a) As determined by the commissioner, in consultation with stakeholders, a provider enrolled to provide services with rates determined under this chapter must submit requested cost data to the commissioner to support evaluation of the rate methodologies in this chapter. Requested cost data may include but is not limited to:

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

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

(c) The commissioner shall coordinate the cost reporting activities required under this section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

(d) The commissioner shall analyze cost documentation in paragraph (a) and, in consultation with stakeholders, may submit recommendations on rate methodologies in this chapter, including ways to monitor and enforce the spending requirements directed in section 256S.2101, subdivision 3, through the reports directed by subdivision 2.

EFFECTIVE DATE. Subdivisions 1 and 2 are effective January 1, 2024. Subdivision 3 is effective January 1, 2025."

Page 46, delete line 17

Page 62, line 16, delete the first "$875,000" and insert "$1,000,000" and delete "$875,000 in fiscal year 2025, $875,000" and insert "$1,000,000"

Page 64, line 12, delete "March ..." and insert "February 27"

Page 64, after line 12, insert:

"Sec. 75. **MEMORANDUMS OF UNDERSTANDING.**

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

Page 65, line 29, delete "and essential community supports"

Page 66, after line 9, insert:

"Sec. 82. **BUDGET INCREASE FOR CONSUMER-DIRECTED COMMUNITY SUPPORTS.**

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

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

Sec. 83. **ACUTE CARE TRANSITIONS TEMPORARY PAYMENT PROGRAM.**

Subdivision 1. **Program established.** The commissioner of human services must establish a temporary provider payment program to address barriers for people with complex, high-acuity needs transitioning from acute care settings to services provided in the community and long-term services and supports.

Subd. 2. **Eligible persons served.** For the purpose of this program, a person with "complex, high-acuity needs" means a person eligible for Medical Assistance or MinnesotaCare who:

(1) is residing in an acute-care setting but no longer clinically meets the level of need;

(2) has experienced repeated service terminations, admission denials to residential settings, placement on a waitlist, or other documented inability of service providers to support the person in a community setting; and

(3) either has a medically complex need that requires highly specialized care, coordination, and treatment or has a history of serious aggressive or self-harming behavior.

Subd. 3. **Eligible service providers.** Providers enrolled in Minnesota health care programs providing behavioral health or long-term services and supports are eligible to apply for the temporary provider payment program prior to or upon serving a person with complex, high-acuity needs as defined in subdivision 2. Eligible providers must be able to demonstrate the specific costs required to serve the individual person as specified in subdivision 4.

Subd. 4. **Eligible costs and payments.** The commissioner shall determine the application process, program requirements, and payment amounts. Payments must be for documented costs necessary to support the individual person with complex, high-acuity needs. Eligible costs must not be reimbursable by other service payments or funding sources, are subject to approval by the commissioner, and are subject to available funds."

Page 80, line 4, strike everything after "used" and insert "to meet the agency's duties under section 626.557 and"

Page 80, line 5, delete the new language and insert "to stop, prevent, and reduce risks of maltreatment for adults accepted for services under section 626.557, or for multidisciplinary teams under section 626.5571"

Page 80, line 6, delete the new language

Page 80, line 8, delete "the"

Page 80, line 9, delete "base of" and after "county" insert "or Tribal" and after "expenditures" insert "for the fiscal year 2023 base"

Page 80, line 10, after the period, insert "This prohibition on county or Tribal expenditures supplanting state money ends July 1, 2027."

Page 80, delete lines 13 to 15

Page 81, line 5, delete "1a" and insert "4a"

Page 81, after line 14, insert:

"Sec. 3. Minnesota Statutes 2022, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 1a, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17."

Page 84, line 5, after "must" insert "also"

Page 84, line 10, after "245.4863" insert ", except when the comprehensive assessment is being completed as part of a diagnostic assessment according to section 245I.10, subdivision 6" and delete "and"

Page 84, after line 10, insert:

"(3) a risk rating and summary to support the risk ratings within each of the dimensions listed in section 254B.04, subdivision 4; and"

Page 84, line 11, delete "(3)" and insert "(4)"and delete "the ASAM level of care; for programs receiving payment"

Page 84, line 12, delete "under chapter 254B," and delete "must be"

Page 84, line 18, delete "and"

Page 84, line 19, delete the period and insert "; and"

Page 84, after line 19, insert:

"(5) a risk rating and summary within each of the six dimensions as identified in section 254B.04, subdivision 4."

Page 84, line 26, strike "and within five calendar days"

Page 85, line 15, delete "an" and insert "a client's"

Page 85, line 16, delete "individual's"

Page 85, line 22, after "goals" insert "in relation to any or all of the applicable ASAM six dimensions identified in section 254B.04, subdivision 4, to ensure measurable treatment objectives, a treatment strategy, and a schedule for accomplishing the client's treatment goals and objectives"

Page 85, line 23, delete everything after "(4)" and insert "document in the treatment plan the ASAM level of care identified in section 254B.05, subdivision 5, paragraph (b), clause (1), that the client is receiving services under;"

Page 85, delete lines 24 to 26

Page 86, delete section 8 and insert:

"Sec. 9. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that the alcohol and drug counselor responsible for a client's treatment plan completes and documents a treatment plan review that meets the requirements of subdivision 3 in each client's file according to the frequencies required in this subdivision. All ASAM levels referred to in this chapter are those described in section 254B.05, subdivision 5.

(b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services, a treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving opioid treatment program services according to section 245G.22, a treatment plan review must be completed weekly for the ten weeks following completion of the treatment plan and monthly thereafter. Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) Notwithstanding paragraphs (e) and (f), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days.

Sec. 11. Minnesota Statutes 2022, section 245G.06, subdivision 4, is amended to read:

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section ~~245G.05, subdivision 2, paragraph (c)~~ 254B.04, subdivision 4, and include the following information:

(1) the client's issues, strengths, and needs while participating in treatment, including services provided;

(2) the client's progress toward achieving each goal identified in the individual treatment plan;

(3) a risk description according to section 245G.05;

(4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);

(5) the client's living arrangements at service termination;

(6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and

(7) service termination diagnosis."

Page 88, after line 11, insert:

"Sec. 12. Minnesota Statutes 2022, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** Client records must contain the following:

(1) documentation that the client was given information on client rights and responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record must contain documentation that the client was provided educational information according to section 245G.05, subdivision 1, paragraph (b);

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

~~(4) an assessment summary completed according to section 245G.05, subdivision 2;~~

~~(5)~~ (4) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

~~(6)~~ (5) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;

~~(7)~~ (6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, and 3; and

~~(8)~~ (7) a summary at the time of service termination according to section 245G.06, subdivision 4.

Sec. 13. Minnesota Statutes 2022, section 245G.11, subdivision 8, is amended to read:

Subd. 8. **Recovery peer qualifications.** ~~A recovery peer must:~~

~~(1) have a high school diploma or its equivalent;~~

~~(2) have a minimum of one year in recovery from substance use disorder;~~

~~(3) hold a current credential from the Minnesota Certification Board, the Upper Midwest Indian Council on Addictive Disorders, or the National Association for Alcoholism and Drug Abuse Counselors. An individual may also receive a credential from a tribal nation when providing peer recovery support services in a tribally licensed program. The credential~~

~~must demonstrate skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and~~

~~(4) receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor.~~

(a) A recovery peer must meet the qualifications in section 245I.04, subdivision 18.

(b) A recovery peer, under the supervision of an alcohol and drug counselor, must provide services according to the scope of practice in section 245I.04, subdivision 19.

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

Page 88, delete lines 26 and 27 and insert "ensure the service is documented according to the requirements in section 245G.06, subdivision 2a"

Page 88, line 28, delete the new language

Page 88, strike lines 31 and 32

Page 89, strike lines 1 to 4

Page 89, line 5, strike "(3)" and insert "(c) Notwithstanding the treatment plan review frequencies in section 245G.06,"

Page 89, line 8, reinstate the stricken language

Page 89, line 21, delete "Peer recovery" and insert "Recovery peer"

Page 92, after line 26, insert:

"Sec. 19. Minnesota Statutes 2022, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The commissioner shall prioritize civilly committed patients who are determined by the Office of Medical Director or a designee to require emergency admission to a state-operated treatment program as well as patients being admitted from jail or a correctional institution who are:

(1) ordered confined in a state-operated treatment program for an examination under Minnesota Rules of Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

(2) under civil commitment for competency treatment and continuing supervision under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

(3) found not guilty by reason of mental illness under Minnesota Rules of Criminal Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be detained in a state-operated treatment program pending completion of the civil commitment proceedings; or

(4) committed under this chapter to the commissioner after dismissal of the patient's criminal charges.

Patients described in this paragraph must be admitted to a state-operated treatment program within 48 hours of the Office of Medical Director or a designee determining that a medically appropriate bed is available. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d).

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the commissioner of human services for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or commissioner, provide copies of the patient's medical and behavioral records to the Department of Human Services for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws."

Page 94, line 11, strike "Licensure required" and insert "Eligible vendors"

Page 95, after line 29, insert:

"(f) A public benefit corporation is an eligible vendor of recovery peer services. Eligible vendors under this paragraph are subject to utilization reviews by the state medical review agent and must:

(1) make available, upon request of the commissioner, a written description of the corporation's governance structure and identify whether (i) the owner shall assume sole responsibility for the activities required in this section, or (ii) the corporation is governed by a governing body, board of directors, or other governance body;

(2) annually approve a quality assurance plan, review a summary of quality assurance activities, and document actions taken by the corporation in response to the review;

(3) annually review a summary of consumer complaints or grievances and document actions taken by the corporation in response to the complaints or grievances;

(4) ensure multiple opportunities are offered for consumer and peer recovery specialist input regarding the planning, evaluation, delivery, and operation of peer recovery services by persons who are receiving or have received mental health and addiction services and persons who collectively represent a wide range of community interests and demographic characteristics of the surrounding community, such as race, ethnicity, primary spoken language, gender, and socioeconomic status;

(5) provide the corporation's consumer rights policy and grievance procedures to each consumer at the time of intake and upon request; and

(6) establish a planned and systematic approach to performance improvement."

Page 95, line 30, delete "(f)" and insert "(g)"

Page 96, delete section 21

Page 101, after line 23, insert:

"Subd. 3. **Family treatment start-up and capacity-building grants.** The commissioner must establish start-up and capacity-building grants for prospective or new substance use disorder treatment programs that serve parents with their children. Grants must be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) physical plant upgrades to support larger family units;

(2) supporting the expansion or development of programs that provide holistic services, including trauma supports, conflict resolution, and parenting skills;

(3) increasing awareness, education, and outreach utilizing culturally responsive approaches to develop relationships between culturally specific communities and clinical treatment provider programs; and

(4) expanding culturally specific family programs and accommodating diverse family units.

Subd. 4. **Safe recovery sites start-up and capacity-building grants.** (a) The commissioner must establish start-up and capacity-building grants for current or prospective harm reduction organizations to promote health, wellness, safety, and recovery to people who are in active stages of substance use disorder. Grants must be used to establish safe recovery sites that offer harm reduction services and supplies, including but not limited to:

(1) safe injection spaces;

(2) sterile needle exchange;

(3) naloxone rescue kits;

(4) fentanyl and other drug testing;

(5) street outreach;

(6) educational and referral services;

(7) health, safety, and wellness services; and

(8) access to hygiene and sanitation.

(b) The commissioner must conduct local community outreach and engagement in collaboration with newly established safe recovery sites. The commissioner must evaluate the efficacy of safe recovery sites and collect data to measure health-related and public safety outcomes."

Page 107, delete subdivision 3 and insert:

"Subd. 3. **Evidence-based practices.** All services delivered within the ASAM levels of care referenced in section 254B.19, subdivision 1, clauses (1) to (7), must have documentation of the evidence-based practices being utilized as referenced in the most current edition of the ASAM criteria."

Page 113, delete section 29

Page 114, after line 28, insert:

"Sec. 33. Minnesota Statutes 2022, section 256B.0638, subdivision 1, is amended to read:

Subdivision 1. **Program established.** The commissioner of human services, in conjunction with the commissioner of health, shall coordinate and implement an opioid prescribing improvement program to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioid analgesics by health care providers and to support patient-centered, compassionate care for Minnesotans who require treatment with opioid analgesics.

Sec. 34. Minnesota Statutes 2022, section 256B.0638, subdivision 2, is amended to read:

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

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

(c) "Commissioners" means the commissioner of human services and the commissioner of health.

(d) "DEA" means the United States Drug Enforcement Administration.

(e) "Minnesota health care program" means a public health care program administered by the commissioner of human services under this chapter and chapter 256L, and the Minnesota restricted recipient program.

(f) "Opioid ~~disenrollment~~ sanction standards" means ~~parameters~~ clinical indicators defined by the Opioid Prescribing Work Group of opioid prescribing practices that fall outside community standard thresholds for prescribing to such a degree that a provider ~~must be disenrolled~~ may be subject to sanctions under section 256B.064 as a ~~medical assistance~~ Minnesota health care program provider.

(g) "Opioid prescriber" means a licensed health care provider who prescribes opioids to ~~medical assistance~~ Minnesota health care program and MinnesotaCare enrollees under the fee-for-service system or under a managed care or county-based purchasing plan.

(h) "Opioid quality improvement standard thresholds" means parameters of opioid prescribing practices that fall outside community standards for prescribing to such a degree that quality improvement is required.

(i) "Program" means the statewide opioid prescribing improvement program established under this section.

(j) "Provider group" means a clinic, hospital, or primary or specialty practice group that employs, contracts with, or is affiliated with an opioid prescriber. Provider group does not include a professional association supported by dues-paying members.

(k) "Sentinel measures" means measures of opioid use that identify variations in prescribing practices during the prescribing intervals.

Sec. 35. Minnesota Statutes 2022, section 256B.0638, subdivision 4, is amended to read:

Subd. 4. **Program components.** (a) The working group shall recommend to the commissioners the components of the statewide opioid prescribing improvement program, including, but not limited to, the following:

(1) developing criteria for opioid prescribing protocols, including:

(i) prescribing for the interval of up to four days immediately after an acute painful event;

(ii) prescribing for the interval of up to 45 days after an acute painful event; and

(iii) prescribing for chronic pain, which for purposes of this program means pain lasting longer than 45 days after an acute painful event;

(2) developing sentinel measures;

(3) developing educational resources for opioid prescribers about communicating with patients about pain management and the use of opioids to treat pain;

(4) developing opioid quality improvement standard thresholds and opioid ~~disenrollment~~ standards for opioid prescribers and provider groups~~. In developing opioid disenrollment standards, the standards may be described in terms of the length of time in which prescribing practices fall outside community standards and the nature and amount of opioid prescribing that fall outside community standards~~; and

(5) addressing other program issues as determined by the commissioners.

(b) The opioid prescribing protocols shall not apply to opioids prescribed for patients who are experiencing pain caused by a malignant condition or who are receiving hospice care or palliative care, or to opioids prescribed for substance use disorder treatment with medications for opioid use disorder.

(c) All opioid prescribers who prescribe opioids to Minnesota health care program enrollees must participate in the program in accordance with subdivision 5. Any other

prescriber who prescribes opioids may comply with the components of this program described in paragraph (a) on a voluntary basis.

Sec. 36. Minnesota Statutes 2022, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the ~~programs within the Minnesota health care~~ quality improvement program to improve the health of and quality of care provided to Minnesota health care program enrollees. The program must be designed to support patient-centered care consistent with community standards of care. The program must discourage unsafe tapering practices and patient abandonment by providers. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) ~~appropriate use of the prescription monitoring program under section 152.126~~ demonstration of patient-centered care consistent with community standards of care.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices for treatment of acute or postacute pain do not improve so that they are consistent with community standards, the commissioner ~~shall~~ may take one or more of the following steps:

(1) require the prescriber, the provider group, or both, to monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts~~, including but not limited to mandatory use of the prescription monitoring program established under section 152.126~~.

(d) Prescribers treating patients who are on chronic, high doses of opioids must meet community standards of care, including performing regular assessments and addressing unwarranted risks of opioid prescribing, but are not required to show measurable changes in chronic pain prescribing thresholds within a certain period.

(e) The commissioner shall dismiss a prescriber from participating in the opioid prescribing quality improvement program when the prescriber demonstrates that the prescriber's practices are patient-centered and reflect community standards for safe and compassionate treatment of patients experiencing pain.

~~(d)~~ (f) The commissioner ~~shall terminate from Minnesota health care programs~~ may investigate for possible sanctions under section 256B.064 all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid ~~disenrollment~~ sanction standards.

(e) No physician, advanced practice registered nurse, or physician assistant, acting in good faith based on the needs of the patient, may be disenrolled by the commissioner of human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations specified in state or federal opioid prescribing guidelines or policies, or quality improvement thresholds established under this section.

Sec. 37. Minnesota Statutes 2022, section 256B.0638, is amended by adding a subdivision to read:

Subd. 8. **Sanction standards.** (a) Providers enrolled in medical assistance under section 256B.04, subdivision 21, providing services to persons enrolled in medical assistance or MinnesotaCare may be subject to sanctions under section 256B.064 for the following practices:

(1) discontinuing, either abruptly or in the form of a rapid taper, chronic opioid analgesic therapy from daily doses greater or equal to 50 morphine milligram equivalents a day without providing patient support. Discontinuing without providing patient support includes failing to:

(i) document and communicate to the patient a clinical rationale for the opioid discontinuation and for the taper plan or speed;

(ii) ascertain pregnancy status in women of childbearing age prior to beginning the discontinuation;

(iii) provide adequate follow-up care to the patient during the opioid discontinuation;

(iv) document a safety and pain management plan prior to or during the discontinuation;

(v) respond promptly and appropriately to patient-expressed psychological distress, including but not limited to suicidal ideation;

(vi) assess the patient for active, moderate to severe substance use disorder, including but not limited to opioid use disorder, and refer or treat the patient as appropriate; or

(vii) document and address patient harm when it arises. This includes but is not limited to known harms reported by the patient, harms evident in a clinical evaluation, or harms that should have been known through adequate chart review;

(2) continuing chronic opioid analgesic therapy without a safety plan when specific red flags for opioid use disorder are present. Failure to develop a safety plan includes but is not limited to failing to:

(i) document and address risks related to the condition or patterns of behavior and the potential health consequences that an undiagnosed or untreated opioid use disorder poses to the patient;

(ii) pursue a diagnosis when an opioid use disorder is suspected;

(iii) include a clear explanation of the safety plan in the patient's health record and evidence that the plan was communicated to the patient; and

(iv) document the clinical rationale for continuing therapy despite the presence of red flags. Red flags for opioid use disorder that require provider response under this section include:

(A) a history of overdose known to the prescriber or evident from the patient's medical record in the past 12 months;

(B) a history of an episode of opioid withdrawal that is not otherwise explained and is known to the prescriber or evident from the patient's medical record in the past 12 months;

(C) a known history of opioid use disorder. If the opioid use disorder is moderate to severe and the diagnosis was made within the past 12 months, a higher degree of consideration must be included in the safety plan;

(D) a history of opioid use resulting in neglect of other aspects of the patient's health that may result in serious harm known to the prescriber or evident from the patient's medical record in the past 12 months;

(E) an active alcohol use disorder. If the alcohol use disorder is moderate to severe, a higher degree of consideration must be included in the safety plan;

(F) a close personal contact of the patient expressing credible concern about the practice of use or safety of the patient indicating imminent harm to the patient or an opioid use disorder diagnosis;

(G) a pattern of deceptive actions by the patient to obtain opioid prescriptions. Deceptive actions may include but are not limited to forging prescriptions, tampering with prescriptions, and falsely reporting to medical staff with the intent of obtaining or protecting an opioid supply;

(H) a pattern of behavior by the patient that is indicative of loss of control or continued opioid use despite harm. Behaviors indicating a loss of control or continued use include but are not limited to a pattern of recurrent lost prescriptions, patient requests to increase dosage that are not supported by clinical reasoning, and a pattern of early refill requests without a change in clinical condition;

(3) prescribing greater than 400 morphine milligram equivalents per day without assessment of the risk for opioid-induced respiratory depression, without responding to evidence of opioid-related harm, and without mitigating the risk of opioid-induced respiratory depression. Failure to address risk of opioid-related harm includes but is not limited to failure to:

(i) assess and document the diagnosis or diagnoses to be managed with chronic opioid analgesic therapy;

(ii) assess and document comorbid health conditions that may impact the safety of opioid therapy;

(iii) screen and document a patient-specific, opioid-related risk benefit analysis;

(iv) respond to evidence of harm within the patient's medical record. Evidence of harm includes but is not limited to opioid-related falls, nonfatal overdoses, and appearing sedated or with respiratory compromise at clinical visits;

(v) document clinical decision making if dosage is increased;

(vi) document discussion of an opioid taper with the patient on at least an annual basis; and

(vii) evaluate the patient in person at least every three months or failing to assess for diversion;

(4) continuing chronic opioid analgesic therapy at the same dosage without a safety plan when risk factors for serious opioid-induced respiratory depression are present. Failing to develop a safety plan includes failing to document the risk factor as a risk of opioid-induced respiratory depression in the patient's health record and failing to document a clear safety plan in the patient's health record that addresses actions to reduce the risk for serious opioid-induced respiratory depression. Risk factors for serious opioid-induced respiratory depression include but are not limited to:

(i) an active or symptomatic and untreated substance use disorder;

(ii) a serious mental health condition, including symptomatic, untreated mania; symptomatic, untreated psychosis; and symptomatic, untreated suicidality;

(iii) an emergency department visit with a life-threatening opioid complication in the last 12 months;

(iv) a pattern of inconsistent urine toxicology results, excluding the presence of cannabinoids; however, addressing an inconsistent urine toxicology result must not result in the overall worsening clinical status of the patient;

(v) the concurrent prescribing of long-term benzodiazepine therapy to an individual on chronic opioid analgesic therapy;

(vi) a pulmonary disease with respiratory failure or hypoventilation; and

(vii) a failure to select and dose opioids safely for patients with known renal insufficiency; and

(5) failing to participate in the Opioid Prescribing Improvement program for two consecutive years.

Sec. 38. Minnesota Statutes 2022, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** (a) The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a

pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

(b) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (h).

(c) The commissioner may impose sanctions against a vendor for violations of the sanction standards defined by the Opioid Prescribing Work Group for opioid prescribing practices that fall outside community standard thresholds for prescribing.

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

Page 115, after line 11, insert:

"(c) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter and are licensed as a hospital under sections 144.50 to 144.581 must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025."

Page 115, line 12, strike "(c)" and insert "(d)"

Page 115, line 17, strike "(d)" and insert "(e)"

Page 115, line 21, strike "(e)" and insert "(f)"

Page 115, line 25, strike "(f)" and insert "(g)"

Page 116, line 4, strike "(g)" and insert "(h)" and strike "(f)" and insert "(g)"

Page 116, delete sections 33 and 34

Page 117, line 4, delete the new language and insert "MEDICAL ASSISTANCE BEHAVIORAL HEALTH SYSTEM TRANSFORMATION STUDY."

Page 117, delete lines 5 and 6

Page 117, line 8, after "healing" insert a comma

Page 117, line 9, after "facilities" insert a comma

Page 117, line 13, after "necessary" insert "changes to"

Page 117, delete section 38 and insert:

"Sec. 38. **REPEALER.**

(a) Minnesota Statutes 2022, sections 245G.06, subdivision 2; and 256B.0759, subdivision 6, are repealed.

(b) Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2023. Paragraph (b) is effective July 1, 2023."

Page 121, delete section 8 and insert:

"Sec. 8. **[246C.05] EMPLOYEE PROTECTIONS FOR ESTABLISHING THE NEW DEPARTMENT OF DIRECT CARE AND TREATMENT.**

(a) Personnel relating to the functions assigned to the commissioner of direct care and treatment in section 143.03 are transferred to the Department of Direct Care and Treatment effective 30 days after approval by the commissioner of direct care and treatment.

(b) Before the commissioner of direct care and treatment's appointment, personnel relating to the functions in this section may be transferred beginning July 1, 2024, with 30 days' notice from the commissioner of management and budget.

(c) The following protections shall apply to employees who are transferred from the Department of Human Services to the Department of Direct Care and Treatment:

(1) No transferred employee shall have their employment status and job classification altered as a result of the transfer.

(2) Transferred employees who were represented by an exclusive representative prior to the transfer shall continue to be represented by the same exclusive representative after the transfer.

(3) The applicable collective bargaining agreements with exclusive representatives shall continue in full force and effect for such transferred employees after the transfer.

(4) The state shall have the obligation to meet and negotiate with the exclusive representatives of the transferred employees about any proposed changes affecting or relating

to the transferred employees' terms and conditions of employment to the extent such changes are not addressed in the applicable collective bargaining agreement.

(5) In the event that the state transfers ownership or control of any of the facilities, services, or operations of the Department of Direct Care and Treatment to another entity, whether private or public, by subcontracting, sale, assignment, lease, or other transfer, the state shall require as a written condition of such transfer of ownership or control the following:

(i) Employees who perform work in transferred facilities, services, or operations must be offered employment with the entity acquiring ownership or control before the entity offers employment to any individual who was not employed by the transferring agency at the time of the transfer.

(ii) The wage and benefit standards of such transferred employees must not be reduced by the entity acquiring ownership or control through the expiration of the collective bargaining agreement in effect at the time of the transfer or for a period of two years after the transfer, whichever is longer.

(d) There is no liability on the part of, and no cause of action arises against, the state of Minnesota or its officers or agents for any action or inaction of any entity acquiring ownership or control of any facilities, services, or operations of the Department of Direct Care and Treatment.

EFFECTIVE DATE. This section is effective July 1, 2024."

Page 121, after line 30, insert:

"ARTICLE 5

SUBSTANCE USE DISORDER

Section 1. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific injured persons or entities, this section does not prohibit distribution of money to the specific injured persons or entities on whose behalf the litigation or settlement efforts were initiated. If money recovered on behalf of injured persons or entities cannot reasonably be distributed to those persons or entities because they cannot readily be located or identified or because the cost of distributing the money would outweigh the benefit to the persons or entities, the money must be paid into the general fund.

(b) Money recovered on behalf of a fund in the state treasury other than the general fund may be deposited in that fund.

(c) This section does not prohibit a state official from distributing money to a person or entity other than the state in litigation or potential litigation in which the state is a defendant or potential defendant.

(d) State agencies may accept funds as directed by a federal court for any restitution or monetary penalty under United States Code, title 18, section 3663(a)(3), or United States Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

(e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph (t), may be deposited as provided in section 16A.98, subdivision 12.

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in the settlement account established in the opiate epidemic response fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor, the commissioner shall deposit any money received into the settlement account established within the opiate epidemic response fund under section 256.042, subdivision 1. ~~Notwithstanding section 256.043, subdivision 3a, paragraph (a),~~ any amount deposited into the settlement account in accordance with this paragraph shall be appropriated to the commissioner of human services ~~to award as grants as specified by the opiate epidemic response advisory council in accordance with section 256.043, subdivision 3a, paragraph (d)~~ as specified in section 256.043, subdivision 3a.

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

Sec. 2. **[121A.224] OPIATE ANTAGONISTS.**

(a) A school district or charter school must maintain a supply of opiate antagonists, as defined in section 604A.04, subdivision 1, at each school site to be administered in compliance with section 151.37, subdivision 12.

(b) Each school building must have two doses of nasal naloxone available on site.

(c) The commissioner of health must develop and disseminate to schools a short training video about how and when to administer nasal naloxone. The person having control of the school building must ensure that at least one staff member trained on how and when to administer nasal naloxone is on site when the school building is open to students, staff, or the public, including before school, after school, or weekend activities.

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

Sec. 3. Minnesota Statutes 2022, section 151.065, subdivision 7, is amended to read:

Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state government special revenue fund.

(b) $5,000 of each fee collected under subdivision 1, clauses (6) to (9), and (11) to (15), and subdivision 3, clauses (4) to (7), and (9) to (13), and $55,000 of each fee collected under subdivision 1, clause (16), and subdivision 3, clause (14), shall be deposited in the opiate epidemic response fund established in section 256.043.

~~(c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14), are reduced under section 256.043, $5,000 of the reduced fee shall be deposited in the opiate epidemic response fund in section 256.043.~~

Sec. 4. Minnesota Statutes 2022, section 241.021, subdivision 1, is amended to read:

Subdivision 1. **Correctional facilities; inspection; licensing.** (a) Except as provided in paragraph (b), the commissioner of corrections shall inspect and license all correctional facilities throughout the state, whether public or private, established and operated for the detention and confinement of persons confined or incarcerated therein according to law except to the extent that they are inspected or licensed by other state regulating agencies. The commissioner shall promulgate pursuant to chapter 14, rules establishing minimum standards for these facilities with respect to their management, operation, physical condition, and the security, safety, health, treatment, and discipline of persons confined or incarcerated

therein. These minimum standards shall include but are not limited to specific guidance pertaining to:

(1) screening, appraisal, assessment, and treatment for persons confined or incarcerated in correctional facilities with mental illness or substance use disorders;

(2) a policy on the involuntary administration of medications;

(3) suicide prevention plans and training;

(4) verification of medications in a timely manner;

(5) well-being checks;

(6) discharge planning, including providing prescribed medications to persons confined or incarcerated in correctional facilities upon release;

(7) a policy on referrals or transfers to medical or mental health care in a noncorrectional institution;

(8) use of segregation and mental health checks;

(9) critical incident debriefings;

(10) clinical management of substance use disorders and opioid overdose emergency procedures;

(11) a policy regarding identification of persons with special needs confined or incarcerated in correctional facilities;

(12) a policy regarding the use of telehealth;

(13) self-auditing of compliance with minimum standards;

(14) information sharing with medical personnel and when medical assessment must be facilitated;

(15) a code of conduct policy for facility staff and annual training;

(16) a policy on death review of all circumstances surrounding the death of an individual committed to the custody of the facility; and

(17) dissemination of a rights statement made available to persons confined or incarcerated in licensed correctional facilities.

No individual, corporation, partnership, voluntary association, or other private organization legally responsible for the operation of a correctional facility may operate the facility unless it possesses a current license from the commissioner of corrections. Private

adult correctional facilities shall have the authority of section 624.714, subdivision 13, if the Department of Corrections licenses the facility with the authority and the facility meets requirements of section 243.52.

The commissioner shall review the correctional facilities described in this subdivision at least once every two years, except as otherwise provided, to determine compliance with the minimum standards established according to this subdivision or other Minnesota statute related to minimum standards and conditions of confinement.

The commissioner shall grant a license to any facility found to conform to minimum standards or to any facility which, in the commissioner's judgment, is making satisfactory progress toward substantial conformity and the standards not being met do not impact the interests and well-being of the persons confined or incarcerated in the facility. A limited license under subdivision 1a may be issued for purposes of effectuating a facility closure. The commissioner may grant licensure up to two years. Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license.

The commissioner shall have access to the buildings, grounds, books, records, staff, and to persons confined or incarcerated in these facilities. The commissioner may require the officers in charge of these facilities to furnish all information and statistics the commissioner deems necessary, at a time and place designated by the commissioner.

All facility administrators of correctional facilities are required to report all deaths of individuals who died while committed to the custody of the facility, regardless of whether the death occurred at the facility or after removal from the facility for medical care stemming from an incident or need for medical care at the correctional facility, as soon as practicable, but no later than 24 hours of receiving knowledge of the death, including any demographic information as required by the commissioner.

All facility administrators of correctional facilities are required to report all other emergency or unusual occurrences as defined by rule, including uses of force by facility staff that result in substantial bodily harm or suicide attempts, to the commissioner of corrections within ten days from the occurrence, including any demographic information as required by the commissioner. The commissioner of corrections shall consult with the Minnesota Sheriffs' Association and a representative from the Minnesota Association of Community Corrections Act Counties who is responsible for the operations of an adult correctional facility to define "use of force" that results in substantial bodily harm for reporting purposes.

The commissioner may require that any or all such information be provided through the Department of Corrections detention information system. The commissioner shall post each inspection report publicly and on the department's website within 30 days of completing the inspection. The education program offered in a correctional facility for the confinement or incarceration of juvenile offenders must be approved by the commissioner of education before the commissioner of corrections may grant a license to the facility.

(b) For juvenile facilities licensed by the commissioner of human services, the commissioner may inspect and certify programs based on certification standards set forth in Minnesota Rules. For the purpose of this paragraph, "certification" has the meaning given it in section 245A.02.

(c) Any state agency which regulates, inspects, or licenses certain aspects of correctional facilities shall, insofar as is possible, ensure that the minimum standards it requires are substantially the same as those required by other state agencies which regulate, inspect, or license the same aspects of similar types of correctional facilities, although at different correctional facilities.

(d) Nothing in this section shall be construed to limit the commissioner of corrections' authority to promulgate rules establishing standards of eligibility for counties to receive funds under sections 401.01 to 401.16, or to require counties to comply with operating standards the commissioner establishes as a condition precedent for counties to receive that funding.

(e) The department's inspection unit must report directly to a division head outside of the correctional institutions division.

Sec. 5. Minnesota Statutes 2022, section 241.31, subdivision 5, is amended to read:

Subd. 5. **Minimum standards.** The commissioner of corrections shall establish minimum standards for the size, area to be served, qualifications of staff, ratio of staff to client population, and treatment programs for community corrections programs established pursuant to this section. Plans and specifications for such programs, including proposed budgets must first be submitted to the commissioner for approval prior to the establishment. Community corrections programs must maintain a supply of opiate antagonists, as defined in section 604A.04, subdivision 1, at each correctional site to be administered in compliance with section 151.37, subdivision 12. Each site must have at least two doses of naloxone on site. Staff must be trained on how and when to administer opiate antagonists.

Sec. 6. Minnesota Statutes 2022, section 241.415, is amended to read:

241.415 RELEASE PLANS; SUBSTANCE ABUSE.

The commissioner shall cooperate with community-based corrections agencies to determine how best to address the substance abuse treatment needs of offenders who are being released from prison. The commissioner shall ensure that an offender's prison release plan adequately addresses the offender's needs for substance abuse assessment, treatment, or other services following release, within the limits of available resources. The commissioner must provide individuals with known or stated histories of opioid use disorder with emergency opiate antagonist rescue kits upon release.

Sec. 7. **[245.89] PUBLIC AWARENESS CAMPAIGN.**

(a) The commissioner must establish an ongoing, multitiered public awareness and educational campaign on substance use disorders. The campaign must include strategies to prevent substance use disorder, reduce stigma, and ensure people know how to access treatment, recovery, and harm reduction services.

(b) The commissioner must consult with communities disproportionately impacted by substance use disorder to ensure the campaign centers lived experience and equity. The commissioner may also consult with and establish relationships with media and communication experts, behavioral health professionals, state and local agencies, and community organizations to design and implement the campaign.

(c) The campaign must include awareness-raising and educational information using multichannel marketing strategies, social media, virtual events, press releases, reports, and targeted outreach. The commissioner must evaluate the effectiveness of the campaign and modify outreach and strategies as needed.

Sec. 8. **[245.891] OVERDOSE SURGE ALERT SYSTEM.**

The commissioner must establish a statewide overdose surge text message alert system. The system may include other forms of electronic alerts. The purpose of the system is to prevent opioid overdose by cautioning people to refrain from substance use or to use harm-reduction strategies when there is an overdose surge in the surrounding area. The commissioner may collaborate with local agencies, other state agencies, and harm-reduction organizations to promote and improve the voluntary text service.

Sec. 9. **[245.892] HARM REDUCTION AND CULTURALLY SPECIFIC GRANTS.**

(a) The commissioner must establish grants for Tribal Nations or culturally specific organizations to enhance and expand capacity to address the impacts of the opioid epidemic in their respective communities. Grants may be used to purchase and distribute harm reduction supplies, develop organizational capacity, and expand culturally specific services.

(b) Harm reduction grant funds must be used to promote safer practices and reduce the transmission of infectious disease. Allowable expenses include syringes, fentanyl testing supplies, disinfectants, naloxone rescue kits, safe injection kits, safe smoking kits, sharps disposal, wound care supplies, medication lock boxes, FDA-approved home testing kits for viral hepatitis and HIV, written educational and resource materials, and other supplies approved by the commissioner.

(c) Culturally specific organizational capacity grant funds must be used to develop and improve organizational infrastructure to increase access to culturally specific services and community building. Allowable expenses include funds for organizations to hire staff or consultants who specialize in fundraising, grant writing, business development, and program integrity or other identified organizational needs as approved by the commissioner.

(d) Culturally specific service grant funds must be used to expand culturally specific outreach and services. Allowable expenses include hiring or consulting with cultural advisors, resources to support cultural traditions, and education to empower, develop a sense of community, and develop a connection to ancestral roots.

Sec. 10. Minnesota Statutes 2022, section 245G.08, subdivision 3, is amended to read:

Subd. 3. ~~**Standing order protocol**~~ **Emergency overdose treatment.** A license holder ~~that maintains~~ must maintain a supply of ~~naloxone~~ opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~must~~ and may have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of naloxone on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both.

Sec. 11. **[254B.20] EVIDENCE-BASED TRAINING.**

The commissioner must establish ongoing training opportunities for substance use disorder treatment providers under chapter 245G to increase knowledge and develop skills to adopt evidence-based and promising practices in substance use disorder treatment programs. Training opportunities must support the transition to American Society of Addiction Medicine (ASAM) standards. Training formats may include self or organizational assessments, virtual modules, one-to-one coaching, self-paced courses, interactive hybrid courses, and in-person courses. Foundational and skill-building training topics may include:

(1) ASAM criteria;

(2) person-centered and culturally responsive services;

(3) medical and clinical decision making;

(4) conducting assessments and appropriate level of care;

(5) treatment and service planning;

(6) identifying and overcoming systems challenges;

(7) conducting clinical case reviews; and

(8) appropriate and effective transfer and discharge.

Sec. 12. Minnesota Statutes 2022, section 256.043, subdivision 3, is amended to read:

Subd. 3. **Appropriations from registration and license fee account.** (a) The appropriations in paragraphs (b) to ~~(h)~~ (k) shall be made from the registration and license fee account on a fiscal year basis in the order specified.

(b) The appropriations specified in Laws 2019, chapter 63, article 3, section 1, paragraphs (b), (f), (g), and (h), as amended by Laws 2020, chapter 115, article 3, section 35, shall be made accordingly.

(c) $100,000 is appropriated to the commissioner of human services for grants for overdose antagonist distribution. Grantees may utilize funds for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution.

(d) $2,000,000 is appropriated to the commissioner of human services for grants to Tribal nations and five urban Indian communities for traditional healing practices for American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce.

(e) $277,000 in fiscal year 2024 and $321,000 each year thereafter is appropriated to the commissioner of human services to administer the funding distribution and reporting requirements in paragraph (j).

~~(e)~~ (f) $300,000 is appropriated to the commissioner of management and budget for evaluation activities under section 256.042, subdivision 1, paragraph (c).

~~(d)~~ (g) $249,000 ~~is~~ in fiscal year 2023, $375,000 in fiscal year 2024, and $315,000 each year thereafter are appropriated to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraph ~~(h)~~ (k).

~~(e)~~ (h) $126,000 is appropriated to the Board of Pharmacy for the collection of the registration fees under section 151.066.

~~(f)~~ (i) $672,000 is appropriated to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

~~(g)~~ (j) After the appropriations in paragraphs (b) to ~~(f)~~ (i) are made, 50 percent of the remaining amount is appropriated to the commissioner of human services for distribution to county social service agencies and Tribal social service agency initiative projects authorized under section 256.01, subdivision 14b, to provide child protection services to children and families who are affected by addiction. The commissioner shall distribute this money proportionally to county social service agencies and Tribal social service agency initiative projects based on out-of-home placement episodes where parental drug abuse is the primary reason for the out-of-home placement using data from the previous calendar year. County social service agencies and Tribal social service agency initiative projects receiving funds from the opiate epidemic response fund must annually report to the commissioner on how the funds were used to provide child protection services, including measurable outcomes, as determined by the commissioner. County social service agencies and Tribal social service agency initiative projects must not use funds received under this paragraph to supplant current state or local funding received for child protection services for children and families who are affected by addiction.

~~(h)~~ (k) After the appropriations in paragraphs (b) to ~~(g)~~ (j) are made, the remaining amount in the account is appropriated to the commissioner of human services to award grants as specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042, unless otherwise appropriated by the legislature.

~~(i)~~ (l) Beginning in fiscal year 2022 and each year thereafter, funds for county social service agencies and Tribal social service agency initiative projects under paragraph ~~(g)~~ (j) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph ~~(h)~~ (k) may be distributed on a calendar year basis.

(m) Notwithstanding section 16A.28, funds appropriated in paragraphs (c), (d), (j), and (k) are available for up to three years.

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

Sec. 13. Minnesota Statutes 2022, section 256.043, subdivision 3a, is amended to read:

Subd. 3a. **Appropriations from settlement account.** (a) The appropriations in paragraphs (b) to (e) shall be made from the settlement account on a fiscal year basis in the order specified.

(b) If the balance in the registration and license fee account is not sufficient to fully fund the appropriations specified in subdivision 3, paragraphs (b) to (f), an amount necessary to meet any insufficiency shall be transferred from the settlement account to the registration and license fee account to fully fund the required appropriations.

(c) $209,000 in fiscal year 2023 and $239,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services for the administration of grants awarded under paragraph (e). $276,000 in fiscal year 2023 and $151,000 in fiscal year 2024 and subsequent fiscal years are appropriated to the commissioner of human services to collect, collate, and report data submitted and to monitor compliance with reporting and settlement expenditure requirements by grantees awarded grants under this section and municipalities receiving direct payments from a statewide opioid settlement agreement as defined in section 256.042, subdivision 6.

(d) After any appropriations necessary under paragraphs (b) and (c) are made, an amount equal to the calendar year allocation to Tribal social service agency initiative projects under subdivision 3, paragraph (g), is appropriated from the settlement account to the commissioner of human services for distribution to Tribal social service agency initiative projects to provide child protection services to children and families who are affected by addiction. The requirements related to proportional distribution, annual reporting, and maintenance of effort specified in subdivision 3, paragraph (g), also apply to the appropriations made under this paragraph.

(e) After making the appropriations in paragraphs (b), (c), and (d), the remaining amount in the account is appropriated to the commissioner of human services to award grants as

specified by the Opiate Epidemic Response Advisory Council in accordance with section 256.042.

(f) Funds for Tribal social service agency initiative projects under paragraph (d) and grant funds specified by the Opiate Epidemic Response Advisory Council under paragraph (e) may be distributed on a calendar year basis.

(g) Notwithstanding section 16A.28, funds appropriated in paragraphs (d) and (e) are available for three years.

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

Sec. 14. **[256I.052] OPIATE ANTAGONISTS.**

(a) Site-based or group housing support settings must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, at each housing site to be administered in compliance with section 151.37, subdivision 12.

(b) Each site must have at least two doses of naloxone on site.

(c) Staff on site must have training on how and when to administer opiate antagonists.

Sec. 15. Laws 2019, chapter 63, article 3, section 1, as amended by Laws 2020, chapter 115, article 3, section 35, and Laws 2022, chapter 53, section 12, is amended to read:

Section 1. **APPROPRIATIONS.**

(a) **Board of Pharmacy; administration.** $244,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for onetime information technology and operating costs for administration of licensing activities under Minnesota Statutes, section 151.066. This is a onetime appropriation.

(b) **Commissioner of human services; administration.** $309,000 in fiscal year 2020 is appropriated from the general fund and $60,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for the provision of administrative services to the Opiate Epidemic Response Advisory Council and for the administration of the grants awarded under paragraphs (f), (g), and (h). The opiate epidemic response fund base for this appropriation is $60,000 in fiscal year 2022, $60,000 in fiscal year 2023, $60,000 in fiscal year 2024, and $0 in fiscal year 2025.

(c) **Board of Pharmacy; administration.** $126,000 in fiscal year 2020 is appropriated from the general fund to the Board of Pharmacy for the collection of the registration fees under section 151.066.

(d) **Commissioner of public safety; enforcement activities.** $672,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of public safety for the Bureau of Criminal Apprehension. Of this amount, $384,000 is for drug scientists and lab supplies and $288,000 is for special agent positions focused on drug interdiction and drug trafficking.

(e) **Commissioner of management and budget; evaluation activities.** $300,000 in fiscal year 2020 is appropriated from the general fund and $300,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of management and budget for evaluation activities under Minnesota Statutes, section 256.042, subdivision 1, paragraph (c).

(f) **Commissioner of human services; grants for Project ECHO.** $400,000 in fiscal year 2020 is appropriated from the general fund and $400,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for grants of $200,000 to CHI St. Gabriel's Health Family Medical Center for the opioid-focused Project ECHO program and $200,000 to Hennepin Health Care for the opioid-focused Project ECHO program. The opiate epidemic response fund base for this appropriation is $400,000 in fiscal year 2022, $400,000 in fiscal year 2023, $400,000 in fiscal year 2024, and $0 in fiscal year 2025.

(g) **Commissioner of human services; opioid overdose prevention grant.** $100,000 in fiscal year 2020 is appropriated from the general fund and $100,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services for a grant to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. ~~The opiate epidemic response fund base for this appropriation is $100,000 in fiscal year 2022, $100,000 in fiscal year 2023, $100,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

(h) **Commissioner of human services; traditional healing.** $2,000,000 in fiscal year 2020 is appropriated from the general fund and $2,000,000 in fiscal year 2021 is appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal nations and five urban Indian communities for traditional healing practices to American Indians and to increase the capacity of culturally specific providers in the behavioral health workforce. ~~The opiate epidemic response fund base for this appropriation~~

~~is $2,000,000 in fiscal year 2022, $2,000,000 in fiscal year 2023, $2,000,000 in fiscal year 2024, and $0 in fiscal year 2025.~~

(i) **Board of Dentistry; continuing education.** $11,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Dentistry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(j) **Board of Medical Practice; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Medical Practice to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(k) **Board of Nursing; continuing education.** $17,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Nursing to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(l) **Board of Optometry; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Optometry to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(m) **Board of Podiatric Medicine; continuing education.** $5,000 in fiscal year 2020 is appropriated from the state government special revenue fund to the Board of Podiatric Medicine to implement the continuing education requirements under Minnesota Statutes, section 214.12, subdivision 6.

(n) **Commissioner of health; nonnarcotic pain management and wellness.** $1,250,000 is appropriated in fiscal year 2020 from the general fund to the commissioner of health, to provide funding for:

(1) statewide mapping and assessment of community-based nonnarcotic pain management and wellness resources; and

(2) up to five demonstration projects in different geographic areas of the state to provide community-based nonnarcotic pain management and wellness resources to patients and consumers.

The demonstration projects must include an evaluation component and scalability analysis. The commissioner shall award the grant for the statewide mapping and assessment, and the demonstration project grants, through a competitive request for proposal process. Grants

for statewide mapping and assessment and demonstration projects may be awarded simultaneously. In awarding demonstration project grants, the commissioner shall give preference to proposals that incorporate innovative community partnerships, are informed and led by people in the community where the project is taking place, and are culturally relevant and delivered by culturally competent providers. This is a onetime appropriation.

(o) **Commissioner of health; administration.** $38,000 in fiscal year 2020 is appropriated from the general fund to the commissioner of health for the administration of the grants awarded in paragraph (n).

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

Sec. 16. **OPIATE ANTAGONIST TRAINING GRANTS.**

The commissioner must establish grants to support training on how to safely store opiate antagonists, opioid overdose symptoms and identification, and how and when to administer opiate antagonists. Eligible grantees include correctional facilities or programs, housing programs, and substance use disorder programs.

Sec. 17. **REPEALER.**

Minnesota Statutes 2022, section 256.043, subdivision 4, is repealed.

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

Page 122, lines 17, 20, and 22, delete "(944,000)" and insert "(6,404,000)"

Page 123, line 9, delete "4,429,166,000" and insert "4,462,657,000" and delete "4,750,908,000" and insert "4,777,629,000"

Page 123, line 12, delete "4,423,839,000" and insert "4,457,370,000" and delete "4,475,981,000" and insert "4,774,809,000"

Page 123, line 17, delete "2,566,000" and insert "2,500,000" and delete "2,166,000" and insert "-0-"

Page 123, line 23, delete "14,805,000" and insert "13,576,000" and delete "10,574,000" and insert "9,421,000"

Page 123, line 27, delete "$9,031,000" and insert "$8,858,000"

Page 123, line 28, delete "$9,214,000" and insert "$8,051,000"

Page 123, after line 28, insert:

"Subd. 3. **Central Office; Children and Families** 141,000 306,000

Base level adjustment. The general fund base is $330,000 in fiscal year 2026 and $330,000 in fiscal year 2027."

Page 123, line 31, delete "2,505,000" and insert "2,972,000" and delete "3,032,000" and insert "3,496,000"

Page 124, line 2, delete "46,646,000" and insert "49,027,000" and delete "46,816,000" and insert "49,077,000"

Page 124, after line 11, insert:

"(b) **Age-friendly Minnesota contracts.** $250,000 in fiscal year 2025 is from the general fund to support age-friendly Minnesota diversity, equity, and inclusion contracts. The base for this appropriation is $250,000 in fiscal year 2026, $250,000 in fiscal year 2027, and $0 in fiscal year 2028.

(c) **Community provider capacity activities.** $1,595,000 in fiscal year 2024 and $2,090,000 in fiscal year 2025 are from the general fund to establish and implement an endorsement system to increase home and community-based provider capacity and competency to address transitions from acute care settings to the community. The base for this appropriation is $1,769,000 in fiscal year 2026 and $1769,000 in fiscal year 2027.

(d) **Employment supports alignment study.** $50,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are to conduct an interagency employment supports alignment study. The base for this appropriation is $150,000 in fiscal year 2026 and $100,000 in fiscal year 2027.

(e) **Case management training curriculum.** $377,000 in fiscal year 2024 and $377,000 fiscal year 2025 are to develop and implement

a curriculum and training plan to ensure all lead agency assessors and case managers have the knowledge and skills necessary to fulfill support planning and coordination responsibilities for individuals who use home and community-based disability services and live in own-home settings. These are onetime appropriations."

Page 124, line 12, delete "(b)" and insert "(f)"

Page 124, line 13, delete "$45,376,000" and insert "$48,003,000"

Page 124, line 14, delete "$45,232,000" and insert "$47,881,000"

Page 124, line 19, delete "1,867,000" and insert "7,763,000" and delete "1,994,000" and insert "9,223,000"

Page 124, line 22, delete "66,000" and insert "60,000" and delete "66,000" and insert "-0-"

Page 124, line 23, after "(a)" insert "**Peer specialists certification.**"

Page 124, after line 30, insert:

"(b) **Competency-based training funding for substance use disorder provider community.** $150,000 in fiscal year 2024 and $150,000 in fiscal year 2025 are from the general fund to provide funding for provider participation in clinical training for the transition to American Society of Addiction Medicine standards.

(c) **Public awareness campaign.** $300,000 in fiscal year 2024 and $300,000 in fiscal year 2025 are from the general fund to develop and establish a public awareness campaign targeting the stigma of opioid use disorders with the goal of prevention and education of youth on the dangers of opioids and other

substance use pursuant to Minnesota Statutes, section 245.89.

(d) **Bad batch overdose surge text alert system.** $250,000 in fiscal year 2024 and $250,000 in fiscal year 2025 are from the general fund for development and ongoing funding for a text alert system notifying the public in real time of bad batch overdoses pursuant to Minnesota Statutes, section 245.891.

(e) **Evaluation of recovery site grants.** $100,000 in fiscal year 2025 is from the general fund to provide funding for evaluating the effectiveness of recovery site grant efforts."

Page 124, line 31, delete "(b)" and insert "(f)"

Page 124, line 32, delete "$1,745,000" and insert "$9,005,000"

Page 124, line 33, delete "$1,645,000" and insert "$8,905,000"

Page 124, delete subdivision 6

Page 125, line 4, delete "3,511,719,000" and insert "3,510,038,000" and delete "3,854,899,000" and insert "3,855,324,000"

Page 125, line 5, delete "47,034,000" and insert "46,985,000" and delete "50,637,000" and insert "50,548,000"

Page 125, line 11, delete "101,440,000" and insert "96,738,000" and delete "102,733,000" and insert "98,767,000"

Page 125, delete subdivision 10

Page 125, after line 26, insert:

"(c) **Temporary provider payment program.** $21,254,000 in fiscal year 2024 is for the temporary acute care transitions payment program. This is a onetime appropriation and is available through June 30, 2026."

Page 126, line 18, delete "95,824,000" and insert "97,869,000" and delete "32,460,000" and insert "34,560,000"

Page 127, line 20, delete "$6,440,000" and insert "$6,095,000"

Page 127, line 26, delete "15 percent"

Page 127, line 27, after "appropriation" insert "and is available until June 30, 2025"

Page 127, line 30, delete "$1,610,000" and insert "$1,600,000"

Page 128, line 3, delete "15 percent"

Page 128, line 7, delete "$50,102,000" and insert "$50,750,000"

Page 128, line 12, delete "15 percent"

Page 128, line 13, after "appropriation" insert "and is available until June 30, 2025"

Page 128, line 14, delete "$2,068,000" and insert "$2,100,000"

Page 128, line 15, delete "$68,000" and insert "$100,000"

Page 129, after line 4, insert:

"(k) **HIV/AIDS support services.**
$12,100,000 in fiscal year 2024 is for grants to community-based HIV/AIDS support services providers and for payment of allowed health care costs as defined in Minnesota Statutes, section 256.935. This is a onetime appropriation and is available through June 30, 2025."

Page 129, line 5, delete "(k)" and insert "(l)"

Page 129, line 6, delete "$29,605,000" and insert "$31,605,000"

Page 129, line 7, delete "$29,030,000" and insert "$31,030,000"

Page 129, line 11, delete "1,000,000" and insert "2,375,000" and delete "1,000,000" and insert "6,000,000"

Page 129, after line 13, insert:

"Subd. 14. **Grant Programs; Child Mental Health Grants**	6,400,000	6,421,000

Base level adjustment. The general fund base is $10,671,000 in fiscal year 2026 and $10,671,000 in fiscal year 2027."

Renumber the subdivisions in sequence

Page 129, line 17, delete "5,747,000" and insert "31,447,000" and delete "6,247,000" and insert "21,947,000"

Page 129, line 20, delete "2,000,000" and insert "-0-"

Page 129, delete lines 21 to 23

Page 129, line 24, delete "(b)" and insert "(a) **Start-up grants for culturally specific peer services.**"

Page 129, line 32, delete "(c)" and insert "(b) **Peer workforce grants.**"

Page 130, after line 2, insert:

"(c) **Base level adjustment.** The general fund base is $21,747,000 in fiscal year 2026 and $21,747,000 in fiscal year 2027.

(d) **Safe recovery sites.** $12,500,000 in fiscal year 2024 and $12,500,000 in fiscal year 2025 are for start-up and capacity-building grants for organizations to establish safe recovery sites. Unspent funds in fiscal year 2024 may be expended through June 30, 2025.

(e) **Culturally specific services grants.** $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are for grants to culturally specific providers for technical assistance navigating culturally specific and responsive substance use and recovery programs.

(f) **Culturally specific grant development trainings.** $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for up to four trainings for community members and culturally specific providers for grant writing

training for substance use and recovery programs. This is onetime appropriation.

(g) **Harm reduction supplies for Tribal and culturally specific programs.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are to provide sole source grants to culturally specific communities to purchase syringes, testing supplies, and naloxone.

(h) **Families and family treatment capacity-building and start-up grants.** $10,000,000 in fiscal year 2024 is for start-up and capacity-building grants for family substance use disorder treatment programs. Any unexpended funds are available until June 30, 2029.

(i) **Problem gambling.** $225,000 in fiscal year 2024 and $225,000 in fiscal year 2025 are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families, and research related to problem gambling."

Page 130, line 20, delete "175,350,000" and insert "169,962,000" and delete "183,215,000" and insert "177,152,000"

Page 131, line 6, delete "15,462,000" and insert "21,223,000" and delete "15,776,000" and insert "22,280,000"

Page 131, line 12, delete "74,218,000" and insert "76,296,000" and delete "89,404,000" and insert "90,658,000"

Page 131, line 13, delete "$82,056,000" and insert "$83,310,000"

Page 131, line 14, delete "$82,976,000" and insert "$84,230,000"

Page 131, after line 14, insert:

"Sec. 3. Laws 2021, First Special Session chapter 7, article 16, section 28, as amended by Laws 2022, chapter 40, section 1, is amended to read:

Sec. 28. **CONTINGENT APPROPRIATIONS.**

Any appropriation in this act for a purpose included in Minnesota's initial state spending plan as described in guidance issued by the Centers for Medicare and Medicaid Services for implementation of section 9817 of the federal American Rescue Plan Act of 2021 is contingent upon the initial approval of that purpose by the Centers for Medicare and Medicaid Services, except for the rate increases specified in article 11, sections 12 and 19. This section expires June 30, 2024.

Sec. 4. **DIRECT CARE AND TREATMENT FISCAL YEAR 2023 APPROPRIATION.**

$4,829,000 is appropriated in fiscal year 2023 to the commissioner of human services for operation of direct care and treatment programs. This is a onetime appropriation."

Page 131, after line 31, insert:

"Sec. 6. **REPEALER.**

Minnesota Statutes 2022, section 246.18, subdivisions 2 and 2a, are repealed."

Renumber the sections in sequence and correct the internal references

Renumber the articles in order

Amend the title accordingly