SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2934

(SENATE AUTHORS: HOFFMAN and Abeler)

DATE	D-PG	OFFICIAL STATUS
03/15/2023	1796	Introduction and first reading Referred to Human Services
04/11/2023		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to human services; modifying provisions governing the care provider workforce, aging and disability services, and behavioral health; establishing the Department of Behavioral Health; making forecast adjustments; requiring reports; making technical and conforming changes; establishing certain grants; appropriating money; amending Minnesota Statutes 2022, sections 15.01; 15.06, subdivision 1; 43A.08, subdivision 1a; 177.24, by adding a subdivision; 245A.10, subdivision 3; 245D.03, subdivision 1; 245G.01, by adding subdivisions; 245G.05, subdivision 1, by adding a subdivision; 245G.06, subdivisions 1, 3, by adding subdivisions; 245G.07, subdivision 2; 245G.22, subdivision 15; 245I.04, subdivision 10, by adding subdivisions; 245I.10, subdivision 6; 252.44; 254B.01, subdivision 8, by adding subdivisions; 254B.05, subdivisions 1, 1a, 5; 256.042, subdivisions 2, 4; 256.045, subdivision 3; 256.478, subdivision 2; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0615, subdivisions 1, 5; 256B.0625, subdivisions 17, 17b, 18a, 18h; 256B.0759, subdivision 2; 256B.0911, subdivision 13; 256B.0913, subdivisions 4, 5; 256B.092, subdivision 1a; 256B.0949, subdivision 15; 256B.49, subdivision 13; 256B.4905, subdivisions 4a, 5a; 256B.4912, by adding subdivisions; 256B.4914, subdivisions 3, 5, 5a, 5b, 6, 8, 9, 9a, 14, by adding subdivisions; 256B.5012, by adding a subdivision; 256B.85, by adding a subdivision; 256B.851, subdivisions 5, 6; 256D.425, subdivision 1; 256M.42; 256R.17, subdivision 2; 256R.25; 256R.47; 256S.15, subdivision 2; 256S.18, by adding a subdivision; 256S.19, subdivision 3; 256S.203, subdivisions 1, 2; 256S.21; 256S.2101; 256S.211, by adding subdivisions; 256S.212; 256S.213; 256S.214; 256S.215, subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17; 268.19, subdivision 1; Laws 2021, chapter 30, article 12, section 5, as amended; Laws 2021, First Special Session chapter 7, article 17, sections 8; 16; proposing coding for new law in Minnesota Statutes, chapters 252; 254B; 256; 256B; 256S; proposing coding for new law as Minnesota Statutes, chapter 246C; repealing Minnesota Statutes 2022, sections 245G.06, subdivision 2; 245G.11, subdivision 8; 256B.4914, subdivision 6b; 256S.19, subdivision 4.

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

ARTICLE 1
WORKFORCE

Section 1. Minnesota Statutes 2022, section 177.24, is amended by adding a subdivision to read:

Subd. 6. **Special certificate prohibition.** (a) On or after August 1, 2026, employers must not hire any new employee with a disability at a wage that is less than the highest applicable minimum wage, regardless of whether the employer holds a special certificate from the United States Department of Labor under section 14(c) of the federal Fair Labor Standards Act.

(b) On or after August 1, 2028, an employer must not pay an employee with a disability less than the highest applicable minimum wage, regardless of whether the employer holds a special certificate from the United States Department of Labor under section 14(c) of the federal Fair Labor Standards Act.

Sec. 2. Minnesota Statutes 2022, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and welfare of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community access for disability inclusion, developmental disabilities, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, community alternative care, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disabilities waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disabilities waiver plans;

(5) night supervision services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disabilities, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only;

(7) individual community living support under section 256S.13; and

(8) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion, and developmental disabilities waiver plans.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) positive support services as defined under the brain injury and community access for disability inclusion, community alternative care, and developmental disabilities waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans; and

(iii) specialist services as defined under the current brain injury, community access for disability inclusion, community alternative care, and developmental disabilities waiver plans;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disabilities waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services;

(iv) individualized home support with training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans; and

(v) individualized home support with family training services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disabilities waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community access for disability inclusion waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting;

(iii) community residential services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans provided in a corporate child foster care residence, a community residential setting, or a supervised living facility;

(iv) family residential services as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans provided in a family child foster care residence or a family adult foster care residence; ~~and~~

(v) residential services provided to more than four persons with developmental disabilities in a supervised living facility, including ICFs/DD; and

(vi) life sharing as defined in the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day services under sections 252.41 to 252.46, and as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans;

(iii) day training and habilitation services under sections 252.41 to 252.46, and as defined under the developmental disabilities waiver plan; and

(iv) prevocational services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans; and

(5) employment exploration services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans;

(6) employment development services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans;

(7) employment support services as defined under the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities waiver plans; and

(8) integrated community support as defined under the brain injury and community access for disability inclusion waiver plans beginning January 1, 2021, and community alternative care and developmental disabilities waiver plans beginning January 1, 2023.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2022, section 252.44, is amended to read:

252.44 LEAD AGENCY BOARD RESPONSIBILITIES.

When the need for day services in a county or tribe has been determined under section 252.28, the board of commissioners for that lead agency shall:

(1) authorize the delivery of services according to the support plans and support plan addendums required as part of the lead agency's provision of case management services under sections 256B.0913, subdivision 8; 256B.092, subdivision 1b; 256B.49, subdivision 15; and 256S.10 and Minnesota Rules, parts 9525.0004 to 9525.0036;

(2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; ~~and~~

(3) monitor and evaluate the cost and effectiveness of the services~~.~~;

(4) ensure that on or after August 1, 2026, employers do not hire any new employee at a wage that is less than the highest applicable minimum wage, regardless of whether the employer holds a special certificate from the United States Department of Labor under section 14(c) of the federal Fair Labor Standards Act; and

(5) ensure that on or after August 1, 2028, any day service program, including county, Tribal, or privately funded day services, pay employees with disabilities the highest applicable minimum wage, regardless of whether the employer holds a special certificate from the United States Department of Labor under section 14(c) of the federal Fair Labor Standards Act.

Sec. 4. **[252.54] STATEWIDE DISABILITY EMPLOYMENT TECHNICAL ASSISTANCE CENTER.**

The commissioner must establish a statewide technical assistance center to provide resources and assistance to programs, people, and families to support individuals with disabilities to achieve meaningful and competitive employment in integrated settings. Duties of the technical assistance center include but are not limited to:

(1) offering provider business model transition support to ensure ongoing access to employment and day services;

(2) identifying and providing training on innovative, promising, and emerging practices;

(3) maintaining a resource clearinghouse to serve as a hub of information to ensure programs, people, and families have access to high-quality materials and information;

(4) fostering innovation and actionable progress by providing direct technical assistance to programs; and

(5) cultivating partnerships and mentorship across support programs, people, and families in the exploration of and successful transition to competitive, integrated employment.

Sec. 5. **[252.55] LEAD AGENCY EMPLOYMENT FIRST CAPACITY BUILDING GRANTS.**

The commissioner shall establish a grant program to expand lead agency capacity to support people with disabilities to contemplate, explore, and maintain competitive, integrated employment options. Allowable uses of funds include:

(1) enhancing resources and staffing to support people and families in understanding employment options and navigating service options;

(2) implementing and testing innovative approaches to better support people with disabilities and their families in achieving competitive, integrated employment; and

(3) other activities approved by the commissioner.

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

Sec. 6. **[256.4761] PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED COMMUNITIES.**

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

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

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

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

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

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

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

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

(1) expanding existing services;

(2) increasing access in rural or underserved areas;

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

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

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

Sec. 7. **[256.4762] SUPPORTING NEW AMERICANS IN THE LONG-TERM CARE WORKFORCE GRANTS.**

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

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

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

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

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

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

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

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

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

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

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

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

(i) course fees;

(ii) child care costs;

(iii) transportation costs;

(iv) tuition fees;

(v) financial coaching fees; or

(vi) mental health supports and uniforms costs incurred as a direct result of participating in classroom instruction or training; or

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

Sec. 8. Minnesota Statutes 2022, section 256B.0911, subdivision 13, is amended to read:

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

(b) MnCHOICES certified assessors must:

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

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

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

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

Sec. 9. Minnesota Statutes 2022, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 26, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

(4) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other

alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; ~~and~~

(9) the person is making timely payments of the assessed monthly fee. A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments~~.~~; and

(10) for a person participating in consumer-directed community supports, the person's monthly service limit must be equal to the monthly service limits in clause (7), except that a person assigned a case mix classification L must receive the monthly service limit for case mix classification A.

(b) The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(c) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a

spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(d) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(e) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

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

Sec. 10. Minnesota Statutes 2022, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **Services covered under alternative care.** Alternative care funding may be used for payment of costs of:

(1) adult day services and adult day services bath;

(2) home care;

(3) homemaker services;

(4) personal care;

(5) case management and conversion case management;

(6) respite care;

(7) specialized supplies and equipment;

(8) home-delivered meals;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) family caregiver training and education;

(15) coaching and counseling;

(16) telehome care to provide services in their own homes in conjunction with in-home visits;

(17) consumer-directed community supports ~~under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~;

(18) environmental accessibility and adaptations; and

(19) discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services for all clients served by a lead agency must not exceed 25 percent of that lead agency's annual alternative care program base allocation, except that when alternative care services receive federal financial participation under the 1115 waiver demonstration, funding shall be allocated in accordance with subdivision 17.

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

Sec. 11. Minnesota Statutes 2022, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the person-centered support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options, including all service options available under the waiver plan;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers of chosen services, including:

(i) providers of services provided in a non-disability-specific setting;

(ii) employment service providers;

(iii) providers of services provided in settings that are not controlled by a provider; and

(iv) providers of financial management services;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) reviewing support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. If a county agency contracts for case management services, the county agency must provide each recipient of home and community-based services who is receiving contracted case management services with the contact information the recipient may use to file a grievance with the county agency about the quality of the contracted services the recipient is receiving from a county-contracted case manager. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 10.

(d) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and

relevant medical experts and service providers in the development and annual review of the person-centered support plan and habilitation plan.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ~~ten~~ 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, employment planning, community living planning, self-direction options, and use of technology supports. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers must document completion of training in a system identified by the commissioner of human services.

Sec. 12. Minnesota Statutes 2022, section 256B.0949, subdivision 15, is amended to read:

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

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

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

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

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

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

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

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

(iii) a board-certified behavior analyst; or

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

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

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

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

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

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

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

(2) a person who has:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2022, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the person-centered written support plan within the timelines established by the commissioner and section 256B.0911, subdivision 29;

(2) informing the recipient or the recipient's legal guardian or conservator of service options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers of chosen services, including:

(i) available options for case management service and providers;

(ii) providers of services provided in a non-disability-specific setting;

(iii) employment service providers;

(iv) providers of services provided in settings that are not community residential settings; and

(v) providers of financial management services;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the person-centered support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved person-centered support plan; and

(3) adjustments to the person-centered support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 10.

(d) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ~~ten~~ 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, employment planning, community living planning, self-direction options, and use of technology supports. For the purposes of this section, "person-centered

planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers shall document completion of training in a system identified by the commissioner of human services.

Sec. 14. Minnesota Statutes 2022, section 256B.4905, subdivision 4a, is amended to read:

Subd. 4a. **Informed choice in employment policy.** It is the policy of this state that working-age individuals who have disabilities:

(1) can work and achieve competitive integrated employment with appropriate services and supports, as needed;

(2) make informed choices about their postsecondary education, work, and career goals; ~~and~~

(3) will be offered the opportunity to make an informed choice, at least annually, to pursue postsecondary education or to work and earn a competitive wage~~.~~; and

(4) will be offered benefits planning assistance and supports to understand available work incentive programs and to understand the impact of work on benefits.

Sec. 15. Minnesota Statutes 2022, section 256B.4905, subdivision 5a, is amended to read:

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

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

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

(b) By August 1, 2024, all case managers must complete an employment support planning training course identified by the commissioner. For case managers hired by a lead agency after August 1, 2024, this training must be completed within the first 120 days of providing case management services. Lead agencies must document completion of the training for all case managers in a tracking system identified by the commissioner.

Sec. 16. **[256B.4906] SUBMINIMUM WAGES IN HOME AND COMMUNITY-BASED SERVICES PROHIBITION; REQUIREMENTS.**

Subdivision 1. **Subminimum wage outcome reporting.** (a) A provider of home and community-based services for people with developmental disabilities under section 256B.092 or home and community-based services for people with disabilities under section 256B.49 that holds a credential listed in clause (1) or (2) as of August 1, 2023, must submit data on individuals who are currently being paid subminimum wages or were being paid subminimum wages by the provider organization as of August 1, 2023, to the commissioner:

(1) a certificate through the United States Department of Labor under United States Code, title 29, section 214(c), of the Fair Labor Standards Act authorizing the payment of subminimum wages to workers with disabilities; or

(2) a permit by the Minnesota Department of Labor and Industry under section 177.28.

(b) The following data must be submitted about each individual required under paragraph (a):

(1) name;

(2) date of birth;

(3) identified race and ethnicity;

(4) disability type;

(5) key employment status measures as determined by the commissioner; and

(6) key community-life engagement measures as determined by the commissioner.

(c) The information in paragraph (b) must be submitted in a format determined by the commissioner of human services.

(d) A provider must submit the data required under this section annually on a date specified by the commissioner. The commissioner must give a provider at least 30 calendar days to submit the data following notice of the due date. If a provider fails to submit the requested data by the date specified by the commissioner, the commissioner may delay medical assistance reimbursement until the requested data is submitted.

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

(f) The commissioner must analyze data annually for tracking employment and community-life engagement outcomes.

Subd. 2. **Prohibition of subminimum wages.** Providers of home and community-based services are prohibited from paying a person with a disability wages below the state minimum wage pursuant to section 177.24, or below the prevailing local minimum wage on the basis of the person's disability. A special certificate authorizing the payment of less than the minimum wage to a person with a disability issued pursuant to a law of this state or to a federal law is without effect as of August 1, 2028.

Sec. 17. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision to read:

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

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

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

(3) financial management services for participants who directly employ direct-care staff through consumer support grants under section 256.476; the personal care assistance choice program under section 256B.0659, subdivisions 18 to 20; community first services and supports under section 256B.85; and the consumer-directed community supports option available under the alternative care program, the brain injury waiver, the community alternative care waiver, the community access for disability inclusion waiver, the developmental disabilities waiver, the elderly waiver, and the Minnesota senior health option, except financial management services providers are not required to submit the data listed in subdivision 1a, clauses (7) to (11).

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

(c) For purposes of this subdivision, "direct-care staff" means employees, including self-employed individuals and individuals directly employed by a participant in a

consumer-directed service delivery option, providing direct service to participants under this section. Direct-care staff does not include executive, managerial, or administrative staff.

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

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

Sec. 18. Minnesota Statutes 2022, section 256B.4912, is amended by adding a subdivision to read:

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

Sec. 19. Minnesota Statutes 2022, section 256B.4914, subdivision 3, is amended to read:

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

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

~~(15)~~ (16) night supervision;

~~(16)~~ (17) positive support services;

~~(17)~~ (18) prevocational services;

~~(18)~~ (19) residential support services;

~~(19)~~ (20) respite services;

~~(20)~~ (21) transportation services; and

~~(21)~~ (22) other services as approved by the federal government in the state home and community-based services waiver plan.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. Minnesota Statutes 2022, section 256B.4914, subdivision 5, is amended to read:

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

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

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

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

(3) on ~~July 1, 2026~~ January 1, 2025, and every two years thereafter, based on wage data by SOC from the Bureau of Labor Statistics available 30 months and one day prior to the scheduled update.

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

Sec. 21. Minnesota Statutes 2022, section 256B.4914, subdivision 5a, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. The amendments to clauses (8), (9), and (10) are effective January 1, 2024, or upon federal approval, whichever is later. The amendment to clause (4) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 22. Minnesota Statutes 2022, section 256B.4914, subdivision 5b, is amended to read:

Subd. 5b. **Standard component value adjustments.** The commissioner shall update the client and programming support, transportation, and program facility cost component values as required in subdivisions 6 to 9a and the rates identified in subdivision 19 for changes in the Consumer Price Index. The commissioner shall adjust these values higher or lower, publish these updated values, and load them into the rate management system as follows:

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

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

(3) on ~~July 1, 2026~~ January 1, 2025, and every two years thereafter, by the percentage change in the CPI-U from the date of the previous update to the data available 30 months and one day prior to the scheduled update.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later, except that the amendments to clauses (2) and (3), are effective January 1, 2024, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 23. Minnesota Statutes 2022, section 256B.4914, is amended by adding a subdivision to read:

Subd. 5f. **Competitive workforce factor updates and adjustments.** Beginning January 1, 2025, and every two years thereafter, the commissioner shall update the competitive workforce factor in subdivisions 8, 9, and 9a. The value of the competitive workforce factor must be the value determined in the most recent report under subdivision 10c.

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

Sec. 24. Minnesota Statutes 2022, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Residential support services; generally.** (a) For purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, ~~family residential services,~~ and integrated community supports.

(b) A unit of service for residential support services is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day. The number of days authorized for all individuals enrolling in residential support services must include every day that services start and end.

(c) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential support services after January 1, 2014, then individual staffing hours shall be used.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 25. Minnesota Statutes 2022, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: ~~4.7~~ 8.4 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2022, section 256B.4914, subdivision 9, is amended to read:

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

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

(1) competitive workforce factor: ~~4.7~~ 8.4 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

Sec. 27. Minnesota Statutes 2022, section 256B.4914, subdivision 9a, is amended to read:

Subd. 9a. **Respite services; component values and calculation of payment rates.** (a) For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for respite services are:

(1) competitive workforce factor: ~~4.7~~ 8.4 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

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

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

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;

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

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

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

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

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

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

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio;

(9) this is the subtotal rate;

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

(11) divide the result of clause (9) by one minus the result of clause (10). This is the total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed three; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 28. Minnesota Statutes 2022, section 256B.4914, subdivision 14, is amended to read:

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary,

approve an alternative payment rate for those individuals. Whether granted, denied, or modified, the commissioner shall respond to all exception requests in writing. The commissioner shall include in the written response the basis for the action and provide notification of the right to appeal under paragraph (h).

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

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

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

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

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

(d) Exception requests must include the following information:

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

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

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

(4) any contingencies for approval.

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

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

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

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

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

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

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

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

(m) Rates determined under subdivision 19 are ineligible for rate exceptions.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Subd. 19. **Payments for family residential and life sharing services.** The commissioner shall establish rates for family residential services and life sharing services based on a person's assessed need, as described in the federally-approved waiver plans. Rates for life

sharing services must be ten percent higher than the corresponding family residential services rate.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 30. Minnesota Statutes 2022, section 256B.5012, is amended by adding a subdivision to read:

Subd. 19. **ICF/DD rate transition.** (a) Effective January 1, 2024, the minimum daily operating rate for intermediate care facilities for persons with developmental disabilities is $260.00.

(b) Beginning January 1, 2026, and every two years thereafter, the rate in paragraph (a) must be updated for the percentage change in the Consumer Price Index (CPI-U) from the date of the previous CPI-U update to the data available 12 months and one day prior to the scheduled update.

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

Sec. 31. Minnesota Statutes 2022, section 256B.85, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

Sec. 32. Minnesota Statutes 2022, section 256B.851, subdivision 5, is amended to read:

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

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

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

(3) employee benefits factor, 12.04 percent;

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

(5) program plan support factor, 7.00 percent;

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

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

(8) absence and utilization factor, 3.90 percent.

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

(1) ~~personal care assistance services and CFSS: 75.45 percent;~~ beginning January 1, 2024: 88.19 percent; and

(2) ~~enhanced rate personal care assistance services and enhanced rate CFSS: 75.45 percent; and~~ beginning January 1, 2025: 92.10 percent.

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

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

(1) for workers who have provided fewer than 1,001 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.0 percent;

(2) for workers who have provided between 1,001 and 2,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.0217 percent;

(3) for workers who have provided between 2,001 and 6,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.0436 percent;

(4) for workers who have provided between 6,001 and 10,000 cumulative hours in personal care assistance services or CFSS, the worker retention component is 1.0735 percent; and

(5) for workers who have provided more than 10,000 hours in personal care assistance services or CFSS, the worker retention component is 1.1081 percent.

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

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

Sec. 33. Minnesota Statutes 2022, section 256B.851, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

(9) multiply the total adjusted payment rate by the appropriate staff retention component under subdivision 5, paragraph (b). This is the final payment rate.

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

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

Sec. 34. Minnesota Statutes 2022, section 256D.425, subdivision 1, is amended to read:

Subdivision 1. **Persons entitled to receive aid.** A person who is aged, blind, or 18 years of age or older and disabled and who is receiving supplemental security benefits under Title XVI on the basis of age, blindness, or disability (or would be eligible for such benefits except for excess income) is eligible for a payment under the Minnesota supplemental aid program, if the person's net income is less than the standards in section 256D.44. A person who is receiving benefits under the Minnesota supplemental aid program in the month prior to becoming eligible under section 1619(b) of the Social Security Act is eligible for a payment under the Minnesota supplemental aid program while they remain in section 1619(b) status. Persons who are not receiving Supplemental Security Income benefits under Title XVI of the Social Security Act or disability insurance benefits under Title II of the Social

Security Act due to exhausting time limited benefits are not eligible to receive benefits under the MSA program. Persons who are not receiving Social Security or other maintenance benefits for failure to meet or comply with the Social Security or other maintenance program requirements are not eligible to receive benefits under the MSA program. Persons who are found ineligible for Supplemental Security Income because of excess income, but whose income is within the limits of the Minnesota supplemental aid program, must have blindness or disability determined by the state medical review team.

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

Sec. 35. Minnesota Statutes 2022, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to (o).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to consolidation rate adjustments shall be as determined under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d.

(h) The portion related to single-bed room incentives is as determined under section 256R.41.

(i) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate

taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(j) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(k) The portion related to the Public Employees Retirement Association is the allowable costs divided by the sum of the facility's resident days.

(l) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(m) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(n) The portion related to special dietary needs is the amount determined under section 256R.51.

(o) The portion related to the rate adjustments for border city facilities is the amount determined under section 256R.481.

(p) The portion related to the rate adjustment for critical access nursing facilities is the amount determined under section 256R.47.

Sec. 36. Minnesota Statutes 2022, section 256R.47, is amended to read:

256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) ~~The commissioner shall allow the benefits in clauses (1) to (5)~~ For nursing facilities designated as critical access nursing facilities~~:~~, the commissioner shall allow a supplemental

payment above a facility's operating payment rate as determined to be necessary by the commissioner to maintain access to nursing facilities services in isolated areas identified in paragraph (b). The commissioner must approve the amounts of supplemental payments through a memorandum of understanding. Supplemental payments to facilities under this section must be in the form of time-limited rate adjustments included in the external fixed payment rate under section 256R.25.

~~(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;~~

~~(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;~~

~~(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;~~

~~(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and~~

~~(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.~~

(d) Designation of a critical access nursing facility is for a maximum period of up to two years, after which the ~~benefits~~ benefit allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

~~(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, 2019.~~

(e) The memorandum of understanding required by paragraph (c), clause (1), must state that the designation of a critical access nursing facility must be removed if the facility undergoes a change of ownership as defined in section 144A.06, subdivision 2.

Sec. 37. Minnesota Statutes 2022, section 256S.15, subdivision 2, is amended to read:

Subd. 2. **Foster care limit.** The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the monthly case mix budget cap for the participant as specified in sections 256S.18, subdivision 3, and 256S.19, ~~subdivisions~~ subdivision 3 ~~and~~ ~~4~~.

Sec. 38. Minnesota Statutes 2022, section 256S.18, is amended by adding a subdivision to read:

Subd. 3a. **Monthly case mix budget caps for consumer-directed community supports.** The monthly case mix budget caps for each case mix classification for consumer-directed community supports must be equal to the monthly case mix budget caps in subdivision 3.

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

Sec. 39. Minnesota Statutes 2022, section 256S.19, subdivision 3, is amended to read:

Subd. 3. **Calculation of monthly conversion budget ~~cap without consumer-directed community supports~~ caps.** (a) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports~~ must be based on the nursing facility case mix adjusted total payment rate of the nursing facility where the elderly waiver applicant currently resides for the applicant's case mix classification as determined according to section 256R.17.

(b) The elderly waiver monthly conversion budget cap for the cost of elderly waiver services ~~without consumer-directed community supports shall~~ must be calculated by multiplying the applicable nursing facility case mix adjusted total payment rate by 365, dividing by 12, and subtracting the participant's maintenance needs allowance.

(c) A participant's initially approved monthly conversion budget cap for elderly waiver services ~~without consumer-directed community supports shall~~ must be adjusted at least annually as described in section 256S.18, subdivision 5.

(d) Conversion budget caps for individuals participating in consumer-directed community supports must be set as described in paragraphs (a) to (c).

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

Sec. 40. Minnesota Statutes 2022, section 256S.203, subdivision 1, is amended to read:

Subdivision 1. **Capitation payments.** The commissioner must adjust the elderly waiver capitation payment rates for managed care organizations paid to reflect the monthly service rate limits for customized living services and 24-hour customized living services established under section 256S.202 ~~and~~, the rate adjustments for disproportionate share facilities under section 256S.205, and the assisted living facility closure payments under section 256S.206.

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

Sec. 41. Minnesota Statutes 2022, section 256S.203, subdivision 2, is amended to read:

Subd. 2. **Reimbursement rates.** Medical assistance rates paid to customized living providers by managed care organizations under this chapter must not exceed the monthly service rate limits and component rates as determined by the commissioner under sections 256S.15 and 256S.20 to 256S.202, plus any rate adjustment or special payment under section 256S.205 or 256S.206.

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

Sec. 42. **[256S.206] ASSISTED LIVING FACILITY CLOSURE PAYMENTS.**

Subdivision 1. **Assisted living facility closure payments provided.** The commissioner of human services shall establish a special payment program to support licensed assisted living facilities who serve waiver participants under section 256B.49 and chapter 256S when the assisted living facility is acting to close the facility as outlined in section 144G.57. The payments must support the facility to meet the health and safety needs of residents during facility occupancy and revenue decline.

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

(b) "Closure period" means the number of days in the approved closure plan for the eligible facility as determined by the commissioner of health under section 144G.57, not to exceed 60 calendar days.

(c) "Eligible claim" means a claim for customized living services and 24-hour customized living services provided to waiver participants under section 256B.49 and chapter 256S during the eligible facility's closure period.

(d) "Eligible facility" means a licensed assisted living facility that has an approved closure plan, as determined by the commissioner of health under section 144G.57, that is acting to close the facility and no longer serve residents in that setting. A facility where a provider is relinquishing an assisted living facility license to transition to a different license type is not an eligible facility.

Subd. 3. **Application.** (a) An eligible facility may apply to the commissioner of human services for assisted living closure transition payments in the manner prescribed by the commissioner.

(b) The commissioner shall notify the facility within 14 calendars days of the facility's application about the result of the application, including whether the facility meets the definition of an eligible facility.

Subd. 4. **Issuing closure payments.** (a) The commissioner must increase the payment for eligible claims by 50 percent during the eligible facility's closure period.

(b) The commissioner must direct managed care organizations to increase the payment for eligible claims by 50 percent during the eligible facility's closure period for eligible claims submitted to managed care organizations.

Subd. 5. **Interagency coordination.** The commissioner of human services must coordinate the activities under this section with any impacted state agencies and lead agencies.

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

Sec. 43. Minnesota Statutes 2022, section 256S.21, is amended to read:

256S.21 RATE SETTING; APPLICATION; EVALUATION.

Subdivision 1. **Application of rate setting.** The payment methodologies in sections 256S.2101 to 256S.215 apply to:

(1) elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter;

(2) alternative care under section 256B.0913;

(3) essential community supports under section 256B.0922; and

(4) community access for disability inclusion customized living and brain injury customized living under section 256B.49.

Subd. 2. **Evaluation of rate setting.** (a) Beginning January 1, 2024, and every two years thereafter, the commissioner, in consultation with stakeholders, shall use all available data and resources to evaluate the following rate setting elements:

(1) the base wage index;

(2) the factors and supervision wage components; and

(3) the formulas to calculate adjusted base wages and rates.

(b) Beginning January 15, 2026, and every two years thereafter, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services finance and policy with a full report on the information and data gathered under paragraph (a).

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

Sec. 44. Minnesota Statutes 2022, section 256S.2101, is amended to read:

256S.2101 RATE SETTING; PHASE-IN.

Subdivision 1. **Phase-in for disability waiver customized living rates.** All rates and rate components for community access for disability inclusion customized living and brain injury customized living under section 256B.4914 shall be the sum of ~~ten~~ six percent of the rates calculated under sections 256S.211 to 256S.215 and ~~90~~ 94 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Subd. 2. **Phase-in for elderly waiver rates.** Except for home-delivered meals ~~as described in section 256S.215, subdivision 15~~, all rates and rate components for elderly waiver, elderly waiver customized living, and elderly waiver foster care under this chapter; alternative care under section 256B.0913; and essential community supports under section 256B.0922 shall be:

(1) beginning January 1, 2024, the sum of ~~18.8~~ 27.8 percent of the rates calculated under sections 256S.211 to 256S.215, and ~~81.2~~ 72.2 percent of the rates calculated using the rate

methodology in effect as of June 30, 2017~~. The rate for home-delivered meals shall be the sum of the service rate in effect as of January 1, 2019, and the increases described in section 256S.215, subdivision 15.~~; and

(2) beginning January 1, 2026, the sum of 25 percent of the rates calculated under sections 256S.211 to 256S.215, and 75 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Subd. 3. **Spending requirements.** (a) Except for community access for disability inclusion customized living and brain injury customized living under section 256B.49, at least 80 percent of the marginal increase in revenue from the implementation of any adjustments to the phase-in in subdivision 2, or any updates to services rates directed under section 256S.211, subdivision 3, must be used to increase compensation-related costs for employees directly employed by the provider.

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

(1) wages and salaries;

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

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

(4) benefits that address direct support professional workforce needs above and beyond what employees were offered prior to the implementation of the adjusted phase-in in subdivision 2, including any concurrent or subsequent adjustments to the base wage indices.

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

(d) A provider agency or individual provider that receives additional revenue subject to the requirements of this subdivision shall prepare, and upon request submit to the commissioner, a distribution plan that specifies the amount of money the provider expects to receive that is subject to the requirements of this subdivision, including how that money was or will be distributed to increase compensation-related costs for employees. Within 60 days of final implementation of the new phase-in proportion or adjustment to the base wage indices subject to the requirements of this subdivision, the provider must post the distribution

plan and leave it posted for a period of at least six months in an area of the provider's operation to which all direct support professionals have access. The posted distribution plan must include instructions regarding how to contact the commissioner, or the commissioner's representative, if an employee has not received the compensation-related increase described in the plan.

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

Sec. 45. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision to read:

Subd. 3. **Updating services rates.** On January 1, 2024, and every two years thereafter, the commissioner shall recalculate rates for services as directed in section 256S.215. Prior to recalculating the rates, the commissioner shall:

(1) update the base wage index for services in section 256S.212 based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data;

(2) update the payroll taxes and benefits factor in section 256S.213, subdivision 1, based on the most recently available nursing facility cost report data;

(3) update the supervision wage components in section 256S.213, subdivisions 4 and 5, based on the most recently available Bureau of Labor Statistics Minneapolis-St. Paul-Bloomington, MN-WI MetroSA data; and

(4) update the adjusted base wage for services as directed in section 256S.214.

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

Sec. 46. Minnesota Statutes 2022, section 256S.211, is amended by adding a subdivision to read:

Subd. 4. **Updating home-delivered meals rate.** On January 1 of each year, the commissioner shall update the home-delivered meals rate in section 256S.215, subdivision 15, by the percent increase in the nursing facility dietary per diem using the two most recently available nursing facility cost reports.

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

Sec. 47. Minnesota Statutes 2022, section 256S.212, is amended to read:

256S.212 RATE SETTING; BASE WAGE INDEX.

Subdivision 1. **Updating SOC codes.** If any of the SOC codes and positions used in this section are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Subd. 2. **Home management and support services base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care aide (SOC code ~~39-9021~~ 31-1120); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 3. **Home care aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home care aide base wage equals ~~50~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code ~~31-1011~~ 31-1120); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 4. **Home health aide base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the home health aide base wage equals ~~20~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); ~~and 80~~ 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120).

Subd. 5. **Medication setups by licensed nurse base wage.** For customized living~~,~~ and foster care~~, and residential care~~ component services, the medication setups by licensed nurse base wage equals ~~ten~~ 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and ~~90~~ 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 6. **Chore services base wage.** The chore services base wage equals ~~100~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 7. **Companion services base wage.** The companion services base wage equals ~~50~~ 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care aides (SOC code ~~39-9021~~ 31-1120); and ~~50~~ 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 8. **Homemaker ~~services and~~ assistance with personal care base wage.** The homemaker ~~services and~~ assistance with personal care base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 9. **Homemaker ~~services and~~ cleaning base wage.** The homemaker ~~services and~~ cleaning base wage equals ~~60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20~~ 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

Subd. 10. **Homemaker ~~services and~~ home management base wage.** The homemaker ~~services and~~ home management base wage equals ~~60~~ 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal ~~and home~~ care ~~aide~~ aides (SOC code ~~39-9021~~ 31-1120); ~~20~~ and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131)~~; and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012)~~.

Subd. 11. **In-home respite care services base wage.** The in-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and

personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 12. **Out-of-home respite care services base wage.** The out-of-home respite care services base wage equals ~~five~~ 15 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~nursing assistants~~ home health and personal care aides (SOC code ~~31-1014~~ 31-1120); and ~~20~~ ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

Subd. 13. **Individual community living support base wage.** The individual community living support base wage equals ~~20~~ 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~licensed practical and licensed vocational nurses~~ social and human services assistants (SOC code ~~29-2061~~ 21-1093); and ~~80~~ 40 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code ~~31-1014~~ 31-1131).

Subd. 14. **Registered nurse base wage.** The registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

Subd. 15. ~~**Social worker**~~ **Unlicensed supervisor base wage.** The ~~social worker~~ unlicensed supervisor base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for ~~medical and public health social~~ first-line supervisors of personal service workers (SOC code ~~21-1022~~ 39-1022).

Subd. 16. **Adult day services base wage.** The adult day services base wage equals 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health and personal care aides (SOC code 31-1120); and 25 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1131).

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

Sec. 48. Minnesota Statutes 2022, section 256S.213, is amended to read:

256S.213 RATE SETTING; FACTORS.

Subdivision 1. **Payroll taxes and benefits factor.** The payroll taxes and benefits factor is the sum of net payroll taxes and benefits, divided by the sum of all salaries for all nursing facilities on the most recent and available cost report.

Subd. 2. **General and administrative factor.** The general and administrative factor is ~~the difference of net general and administrative expenses and administrative salaries, divided by total operating expenses for all nursing facilities on the most recent and available cost report~~ 14.4 percent.

Subd. 3. **Program plan support factor.** (a) The program plan support factor is ~~12.8~~ ten percent for the following services to cover the cost of direct service staff needed to provide support for ~~home and community-based~~ the service when not engaged in direct contact with participants~~.~~:

(1) adult day services;

(2) customized living; and

(3) foster care.

(b) The program plan support factor is 15.5 percent for the following services to cover the cost of direct service staff needed to provide support for the service when not engaged in direct contact with participants:

(1) chore services;

(2) companion services;

(3) homemaker assistance with personal care;

(4) homemaker cleaning;

(5) homemaker home management;

(6) in-home respite care;

(7) individual community living support; and

(8) out-of-home respite care.

Subd. 4. **Registered nurse management and supervision ~~factor~~ wage component.** The registered nurse management and supervision ~~factor~~ wage component equals 15 percent of the registered nurse adjusted base wage as defined in section 256S.214.

Subd. 5. **~~Social worker~~ Unlicensed supervisor supervision ~~factor~~ wage component.** The ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component equals 15 percent of the ~~social worker~~ unlicensed supervisor adjusted base wage as defined in section 256S.214.

Subd. 6. **Facility and equipment factor.** The facility and equipment factor for adult day services is 16.2 percent.

Subd. 7. **Food, supplies, and transportation factor.** The food, supplies, and transportation factor for adult day services is 24 percent.

Subd. 8. **Supplies and transportation factor.** The supplies and transportation factor for the following services is 1.56 percent:

(1) chore services;

(2) companion services;

(3) homemaker assistance with personal care;

(4) homemaker cleaning;

(5) homemaker home management;

(6) in-home respite care;

(7) individual community support services; and

(8) out-of-home respite care.

Subd. 9. **Absence factor.** The absence factor for the following services is 4.5 percent:

(1) adult day services;

(2) chore services;

(3) companion services;

(4) homemaker assistance with personal care;

(5) homemaker cleaning;

(6) homemaker home management;

(7) in-home respite care;

(8) individual community living support; and

(9) out-of-home respite care.

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

Sec. 49. Minnesota Statutes 2022, section 256S.214, is amended to read:

256S.214 RATE SETTING; ADJUSTED BASE WAGE.

For the purposes of section 256S.215, the adjusted base wage for each position equals the position's base wage under section 256S.212 plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor under section 256S.213, subdivision 1;

~~(2) the position's base wage multiplied by the general and administrative factor under section 256S.213, subdivision 2; and~~

~~(3)~~ (2) the position's base wage multiplied by the applicable program plan support factor under section 256S.213, subdivision 3~~.~~; and

(3) the position's base wage multiplied by the absence factor under section 256S.213, subdivision 9, if applicable.

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

Sec. 50. Minnesota Statutes 2022, section 256S.215, subdivision 2, is amended to read:

Subd. 2. **Home management and support services component rate.** The component rate for home management and support services is calculated as follows:

(1) sum the home management and support services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

Sec. 51. Minnesota Statutes 2022, section 256S.215, subdivision 3, is amended to read:

Subd. 3. **Home care aide services component rate.** The component rate for home care aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

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

Sec. 52. Minnesota Statutes 2022, section 256S.215, subdivision 4, is amended to read:

Subd. 4. **Home health aide services component rate.** The component rate for home health aide services is calculated as follows:

(1) sum the home health aide services adjusted base wage ~~plus~~ and the registered nurse management and supervision ~~factor.~~ wage component;

(2) multiply the result of clause (1) by the general and administrative factor; and

(3) sum the results of clauses (1) and (2).

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

Sec. 53. Minnesota Statutes 2022, section 256S.215, subdivision 7, is amended to read:

Subd. 7. **Chore services rate.** The 15-minute unit rate for chore services is calculated as follows:

(1) sum the chore services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 54. Minnesota Statutes 2022, section 256S.215, subdivision 8, is amended to read:

Subd. 8. **Companion services rate.** The 15-minute unit rate for companion services is calculated as follows:

(1) sum the companion services adjusted base wage and the ~~social worker~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 55. Minnesota Statutes 2022, section 256S.215, subdivision 9, is amended to read:

Subd. 9. **Homemaker ~~services and~~ assistance with personal care rate.** The 15-minute unit rate for homemaker ~~services and~~ assistance with personal care is calculated as follows:

(1) sum the homemaker ~~services and~~ assistance with personal care adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 56. Minnesota Statutes 2022, section 256S.215, subdivision 10, is amended to read:

Subd. 10. **Homemaker ~~services and~~ cleaning rate.** The 15-minute unit rate for homemaker ~~services and~~ cleaning is calculated as follows:

(1) sum the homemaker ~~services and~~ cleaning adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 57. Minnesota Statutes 2022, section 256S.215, subdivision 11, is amended to read:

Subd. 11. **Homemaker ~~services and~~ home management rate.** The 15-minute unit rate for homemaker ~~services and~~ home management is calculated as follows:

(1) sum the homemaker ~~services and~~ home management adjusted base wage and the ~~registered nurse management and~~ unlicensed supervisor supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 58. Minnesota Statutes 2022, section 256S.215, subdivision 12, is amended to read:

Subd. 12. **In-home respite care services rates.** (a) The 15-minute unit rate for in-home respite care services is calculated as follows:

(1) sum the in-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

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

Sec. 59. Minnesota Statutes 2022, section 256S.215, subdivision 13, is amended to read:

Subd. 13. **Out-of-home respite care services rates.** (a) The 15-minute unit rate for out-of-home respite care is calculated as follows:

(1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

(b) The out-of-home respite care services daily rate equals the 15-minute unit rate for out-of-home respite care services multiplied by 18.

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

Sec. 60. Minnesota Statutes 2022, section 256S.215, subdivision 14, is amended to read:

Subd. 14. **Individual community living support rate.** The individual community living support rate is calculated as follows:

(1) sum the ~~home care aide~~ individual community living support adjusted base wage and the ~~social worker~~ registered nurse management and supervision ~~factor~~ wage component; ~~and~~

(2) multiply the result of clause (1) by the general and administrative factor;

(3) multiply the result of clause (1) by the supplies and transportation factor; and

(4) sum the results of clauses (1) to (3) and divide the result ~~of clause (1)~~ by four.

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

Sec. 61. Minnesota Statutes 2022, section 256S.215, subdivision 15, is amended to read:

Subd. 15. **Home-delivered meals rate.** Effective January 1, 2024, the home-delivered meals rate ~~equals $9.30~~ is $8.17, updated as directed in section 256S.211, subdivision 4. ~~The commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.~~

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

Sec. 62. Minnesota Statutes 2022, section 256S.215, subdivision 16, is amended to read:

Subd. 16. **Adult day services rate.** The 15-minute unit rate for adult day services~~, with an assumed staffing ratio of one staff person to four participants, is the sum of~~ is calculated as follows:

(1) ~~one-sixteenth of the home care aide~~ divide the adult day services adjusted base wage~~, except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ by five to reflect an assumed staffing ratio of one to five;

(2) ~~one-fourth of the registered nurse management and supervision factor~~ sum the result of clause (1) and the registered nurse management and supervision wage component; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (2) by the general and administrative factor;

(4) multiply the result of clause (2) by the facility and equipment factor;

(5) multiply the result of clause (2) by the food, supplies, and transportation factor; and

(6) sum the results of clauses (2) to (5) and divide the result by four.

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

Sec. 63. Minnesota Statutes 2022, section 256S.215, subdivision 17, is amended to read:

Subd. 17. **Adult day services bath rate.** The 15-minute unit rate for adult day services bath is ~~the sum of~~ calculated as follows:

(1) ~~one-fourth of the home care aide~~ sum the adult day services adjusted base wage~~,~~ ~~except that the general and administrative factor used to determine the home care aide services adjusted base wage is 20 percent~~ and the nurse management and supervision wage component;

(2) ~~one-fourth of the registered nurse management and supervision~~ multiply the result of clause (1) by the general and administrative factor; ~~and~~

(3) ~~$0.63 to cover the cost of meals.~~ multiply the result of clause (1) by the facility and equipment factor;

(4) multiply the result of clause (1) by the food, supplies, and transportation factor; and

(5) sum the results of clauses (1) to (4) and divide the result by four.

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

Sec. 64. Minnesota Statutes 2022, section 268.19, subdivision 1, is amended to read:

Subdivision 1. **Use of data.** (a) Except as provided by this section, data gathered from any person under the administration of the Minnesota Unemployment Insurance Law are private data on individuals or nonpublic data not on individuals as defined in section 13.02, subdivisions 9 and 12, and may not be disclosed except according to a district court order or section 13.05. A subpoena is not considered a district court order. These data may be disseminated to and used by the following agencies without the consent of the subject of the data:

(1) state and federal agencies specifically authorized access to the data by state or federal law;

(2) any agency of any other state or any federal agency charged with the administration of an unemployment insurance program;

(3) any agency responsible for the maintenance of a system of public employment offices for the purpose of assisting individuals in obtaining employment;

(4) the public authority responsible for child support in Minnesota or any other state in accordance with section 256.978;

(5) human rights agencies within Minnesota that have enforcement powers;

(6) the Department of Revenue to the extent necessary for its duties under Minnesota laws;

(7) public and private agencies responsible for administering publicly financed assistance programs for the purpose of monitoring the eligibility of the program's recipients;

(8) the Department of Labor and Industry and the Commerce Fraud Bureau in the Department of Commerce for uses consistent with the administration of their duties under Minnesota law;

(9) the Department of Human Services and the Office of Inspector General and its agents within the Department of Human Services, including county fraud investigators, for investigations related to recipient or provider fraud and employees of providers when the provider is suspected of committing public assistance fraud;

(10) the Department of Human Services for the purpose of evaluating medical assistance services and supporting program improvement;

~~(10)~~ (11) local and state welfare agencies for monitoring the eligibility of the data subject for assistance programs, or for any employment or training program administered by those agencies, whether alone, in combination with another welfare agency, or in conjunction with the department or to monitor and evaluate the statewide Minnesota family investment program and other cash assistance programs, the Supplemental Nutrition Assistance Program, and the Supplemental Nutrition Assistance Program Employment and Training program by providing data on recipients and former recipients of Supplemental Nutrition Assistance Program (SNAP) benefits, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B or 256L or formerly codified under chapter 256D;

~~(11)~~ (12) local and state welfare agencies for the purpose of identifying employment, wages, and other information to assist in the collection of an overpayment debt in an assistance program;

~~(12)~~ (13) local, state, and federal law enforcement agencies for the purpose of ascertaining the last known address and employment location of an individual who is the subject of a criminal investigation;

~~(13)~~ (14) the United States Immigration and Customs Enforcement has access to data on specific individuals and specific employers provided the specific individual or specific employer is the subject of an investigation by that agency;

~~(14)~~ (15) the Department of Health for the purposes of epidemiologic investigations;

~~(15)~~ (16) the Department of Corrections for the purposes of case planning and internal research for preprobation, probation, and postprobation employment tracking of offenders sentenced to probation and preconfinement and postconfinement employment tracking of committed offenders;

~~(16)~~ (17) the state auditor to the extent necessary to conduct audits of job opportunity building zones as required under section 469.3201; and

~~(17)~~ (18) the Office of Higher Education for purposes of supporting program improvement, system evaluation, and research initiatives including the Statewide Longitudinal Education Data System.

(b) Data on individuals and employers that are collected, maintained, or used by the department in an investigation under section 268.182 are confidential as to data on individuals and protected nonpublic data not on individuals as defined in section 13.02, subdivisions 3 and 13, and must not be disclosed except under statute or district court order or to a party named in a criminal proceeding, administrative or judicial, for preparation of a defense.

(c) Data gathered by the department in the administration of the Minnesota unemployment insurance program must not be made the subject or the basis for any suit in any civil proceedings, administrative or judicial, unless the action is initiated by the department.

Sec. 65. Laws 2021, chapter 30, article 12, section 5, as amended by Laws 2021, First Special Session chapter 7, article 17, section 2, is amended to read:

Sec. 5. **GOVERNOR'S COUNCIL ON AN AGE-FRIENDLY MINNESOTA.**

The Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall: (1) work to advance age-friendly policies; and (2) coordinate state, local, and private partners' collaborative work on emergency preparedness, with a focus on older adults, communities, and persons in zip codes most impacted by the COVID-19 pandemic. The Governor's Council on an Age-Friendly Minnesota is extended and expires June 30, ~~2024~~ 2027.

Sec. 66. Laws 2021, First Special Session chapter 7, article 17, section 8, is amended to read:

Sec. 8. **AGE-FRIENDLY MINNESOTA.**

Subdivision 1. **Age-friendly community grants.** (a) This act includes $0 in fiscal year 2022 and $875,000 in fiscal year 2023 for age-friendly community grants. The commissioner

of human services, in collaboration with the Minnesota Board on Aging and the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall develop the age-friendly community grant program to help communities, including cities, counties, other municipalities, tribes, and collaborative efforts, to become age-friendly communities, with an emphasis on structures, services, and community features necessary to support older adult residents over the next decade, including but not limited to:

(1) coordination of health and social services;

(2) transportation access;

(3) safe, affordable places to live;

(4) reducing social isolation and improving wellness;

(5) combating ageism and racism against older adults;

(6) accessible outdoor space and buildings;

(7) communication and information technology access; and

(8) opportunities to stay engaged and economically productive.

The general fund base in this act for this purpose is $875,000 in fiscal year 2024 ~~and $0~~, $875,000 in fiscal year 2025, $875,000 in fiscal year 2025, $875,000 in fiscal year 2026, $875,000 in fiscal year 2027, and $0 in fiscal year 2028.

(b) All grant activities must be completed by March 31, ~~2024~~ 2027.

(c) This subdivision expires June 30, ~~2024~~ 2027.

Subd. 2. **Technical assistance grants.** (a) This act includes $0 in fiscal year 2022 and $575,000 in fiscal year 2023 for technical assistance grants. The commissioner of human services, in collaboration with the Minnesota Board on Aging and the Governor's Council on an Age-Friendly Minnesota, established in Executive Order 19-38, shall develop the age-friendly technical assistance grant program. The general fund base in this act for this purpose is $575,000 in fiscal year 2024 ~~and $0~~, $575,000 in fiscal year 2025, $575,000 in fiscal year 2026, $575,000 in fiscal year 2027, and $0 in fiscal year 2028.

(b) All grant activities must be completed by March 31, ~~2024~~ 2027.

(c) This subdivision expires June 30, ~~2024~~ 2027.

Sec. 67. Laws 2021, First Special Session chapter 7, article 17, section 16, is amended to read:

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

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

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

Sec. 68. **EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION LICENSURE STUDY.**

(a) The commissioner of human services must review the medical assistance early intensive developmental and behavioral intervention (EIDBI) service and evaluate the need for licensure or other regulatory modifications. At a minimum, the evaluation must include:

(1) an examination of current Department of Human Services-licensed programs that are similar to EIDBI;

(2) an environmental scan of licensure requirements for Medicaid autism programs in other states; and

(3) health and safety needs for populations with autism and related conditions.

(b) The commissioner must consult with interested stakeholders, including self-advocates who use EIDBI services, EIDBI providers, parents of youth who use EIDBI services, and advocacy organizations. The commissioner must convene stakeholder meetings to obtain feedback on licensure or regulatory recommendations.

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

Sec. 69. **STUDY TO EXPAND ACCESS TO SERVICES FOR PEOPLE WITH CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS AND DISABILITIES.**

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

Sec. 70. **SELF-DIRECTED WORKER CONTRACT RATIFICATION.**

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

Sec. 71. **SPECIALIZED EQUIPMENT AND SUPPLIES LIMIT INCREASE.**

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

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

Sec. 72. **TEMPORARY GRANT FOR SMALL CUSTOMIZED LIVING PROVIDERS.**

The commissioner must establish a temporary grant for customized living providers that serve six or fewer people in a single-family home and that are transitioning to a community residential services licensure or integrated community supports licensure. Allowable uses of grant money include physical plant updates required for community residential services or integrated community supports licensure, technical assistance to adapt business models and meet policy and regulatory guidance, and other uses approved by the commissioner. License holders of eligible settings must apply for grant money using an application process holders of eligible settings must apply for grant money using an application process determined by the commissioner. Grant money approved by the commissioner is a one-time award of up to $20,000 per eligible setting. To be considered for grant money, eligible

license holders must submit a grant application by June 30, 2024. The commissioner may approve grant applications on a rolling basis.

Sec. 73. **INTERAGENCY EMPLOYMENT SUPPORTS ALIGNMENT STUDY.**

The commissioners of human services, employment and economic development, and education must conduct an interagency alignment study on employment supports for people with disabilities. The study must evaluate:

(1) service rates;

(2) provider enrollment and monitoring standards; and

(3) eligibility processes and people's lived experience transitioning between employment programs.

Sec. 74. **MONITORING EMPLOYMENT OUTCOMES.**

By January 15, 2025, the Departments of Human Services, Employment and Economic Development, and Education must provide the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, and labor with a plan for tracking employment outcomes for people with disabilities served by programs administered by the agencies. This plan must include any needed changes to state law to track supports received and outcomes across programs.

Sec. 75. **PHASE-OUT OF THE USE OF SUBMINIMUM WAGE FOR MEDICAL ASSISTANCE DISABILITY SERVICES.**

The commissioner must seek all necessary amendments to Minnesota's federally approved disability waiver plans to require that people receiving prevocational or employment support services are compensated at or above the state minimum wage or at or above the prevailing local minimum wage no later than August 1, 2028.

Sec. 76. **STUDY ON PRESUMPTIVE ELIGIBILITY FOR LONG-TERM SERVICES AND SUPPORTS.**

(a) The commissioner must study presumptive functional eligibility for people with disabilities and older adults in the following programs:

(1) medical assistance, alternative care, and essential community supports; and

(2) home and community-based services and essential community supports.

(b) The commissioner must evaluate the following in the study of presumptive eligibility within the programs listed in paragraph (a):

(1) current eligibility processes;

(2) barriers to timely eligibility determinations; and

(3) strategies to enhance access to home and community-based services in the least restrictive setting.

(c) By January 1, 2025, the commissioner must report recommendations and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy.

Sec. 77. **REPEALER.**

(a) Minnesota Statutes 2022, section 256B.4914, subdivision 6b, is repealed.

(b) Minnesota Statutes 2022, section 256S.19, subdivision 4, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Paragraph (b) is effective January 1, 2024.

ARTICLE 2
AGING AND DISABILITY SERVICES

Section 1. Minnesota Statutes 2022, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $500 application fee with each new application required under this subdivision. If the applicant is an organization applying for an initial license to provide services under chapter 245D, the applicant shall submit a $4,200 application fee. An applicant for an initial day services facility license under chapter 245D shall submit a $250 application fee with each new application. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to (3), an applicant shall apply for a license to provide services at a specific location.

(1) For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application

to provide services statewide. ~~Notwithstanding paragraph (a), applications received by the commissioner between July 1, 2013, and December 31, 2013, for licensure of services provided under chapter 245D must include an application fee that is equal to the annual license renewal fee under subdivision 4, paragraph (b), or $500, whichever is less. Applications received by the commissioner after January 1, 2014, must include the application fee required under paragraph (a). Applicants who meet the modified application criteria identified in section 245A.042, subdivision 2, are exempt from paying an application fee.~~

(2) For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

(3) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

(c) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.

Sec. 2. Minnesota Statutes 2022, section 256B.056, subdivision 3, is amended to read:

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

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

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

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

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

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

(6) a designated employment incentives asset account is disregarded when determining eligibility for medical assistance for a person age 65 years or older under section 256B.055, subdivision 7. An employment incentives asset account must only be designated by a person who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a 24-consecutive-month period. A designated employment incentives asset account contains qualified assets owned by the person ~~and the person's spouse~~ in the last month of enrollment in medical assistance under section 256B.057, subdivision 9. Qualified assets include retirement and pension accounts, medical expense accounts, and up to $17,000 of the person's other nonexcluded liquid assets. An employment incentives asset account is no longer designated when a person loses medical assistance eligibility for a calendar month or more before turning age 65. A person who loses medical assistance eligibility before age 65 can establish a new designated employment incentives asset account by establishing a new 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. ~~The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7.~~ Persons eligible under this clause are not subject to the provisions in section 256B.059; and

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

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

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

Sec. 3. Minnesota Statutes 2022, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) meets the asset limits in paragraph (d); and

(3) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, advanced practice registered nurse, or physician assistant; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under clause (5).

(1) An enrollee must pay the greater of a $35 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount, except as provided under clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse for the enrollee's failure to pay the required premium when due because the circumstances

were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the enrollee to demonstrate good cause. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) The commissioner is authorized to determine that a premium amount was calculated or billed in error, make corrections to financial records and billing systems, and refund premiums collected in error.

~~(j)~~ (k) For enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15, paragraph (a).

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

Sec. 4. Minnesota Statutes 2022, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (h).

(c) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

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

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

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

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

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

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

(1) adhere to the policies defined by the commissioner;

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

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

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

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

(g) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

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

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

(h) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

(k) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

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

(3) investigate all complaints and appeals.

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

(m) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (h), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services

that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

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

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and ~~$11~~ $13.20 for the base rate and ~~$1.30~~ $1.56 per mile when provided by a nonemergency medical transportation provider;

(4) ~~$13~~ $15.60 for the base rate and ~~$1.30~~ $1.56 per mile for assisted transport;

(5) ~~$18~~ $21.60 for the base rate and ~~$1.55~~ $1.86 per mile for lift-equipped/ramp transport;

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

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

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

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

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

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

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

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

(r) Effective for the first day of each calendar quarter in which the price of gasoline, as posted publicly by the United States Energy Information Administration, exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) up or down by one percent for every increase or decrease of ten cents in the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota, as posted publicly by the United States Energy Information Administration.

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

Sec. 5. Minnesota Statutes 2022, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain ~~odometer and other~~ records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision ~~shall be recovered by the department~~ may be subject to recovery by the commissioner pursuant to section 256B.064.

(b) A nonemergency medical transportation provider must compile transportation trip records that are written in English and legible according to the standard of a reasonable person and that ~~meet~~ include each of the following ~~requirements~~ elements:

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

~~(2)~~ (1) the recipient's name ~~must be on each page of the record~~; ~~and~~

~~(3) each entry in the record must document:~~

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

~~(ii)~~ (2) the date or dates the service is provided, if different than the date the entry was made;

~~(iii)~~ (3) the printed ~~last name, first name, and middle initial~~ name of the driver sufficient to distinguish the driver of service or the driver's provider number;

~~(iv)~~ (4) the date and the signature of the driver attesting ~~to the following: "I certify that I have accurately reported in this record the trip miles I actually drove and the dates and~~

~~times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings."~~ that the record accurately represents the services provided and the actual miles driven, and acknowledging that misreporting information that results in ineligible or excessive payments may result in civil or criminal action;

~~(v)~~ (5) the date and the signature of the recipient or authorized party attesting ~~to the following: "I certify that I received the reported transportation service.", or the signature of the provider of medical services certifying that the recipient was delivered to the provider~~ that transportation services were provided as indicated on the transportation trip record, or the signature of the medical services provider certifying that the recipient was transported to the provider destination. In the event that both the medical services provider and the recipient or authorized party refuse or are unable to provide signatures, the driver must document on the transportation trip record that signatures were requested and not provided;

~~(vi)~~ (6) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

~~(vii)~~ (7) the name or number of the mode of transportation in which the service is provided;

~~(viii)~~ (8) the license plate number of the vehicle used to transport the recipient;

~~(ix) whether the service was ambulatory or nonambulatory;~~

~~(x)~~ (9) the time of the recipient pickup;

~~and~~ (10) the time of the recipient drop-off ~~with "a.m." and "p.m." designations~~;

(11) the odometer reading of the vehicle used to transport the recipient taken at the time of pickup;

(12) the odometer reading of the vehicle used to transport the recipient taken at the time of drop-off;

~~(xi)~~ (13) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

~~(xii)~~ (14) the ~~electronic source~~ documentation indicating the method that was used to ~~calculate driving directions and mileage~~ determine the most direct route.

(c) In determining whether the commissioner will seek recovery, the documentation requirements in this section apply retroactively to audit findings beginning January 1, 2020, and to all audit findings thereafter.

Sec. 6. Minnesota Statutes 2022, section 256B.0625, subdivision 18a, is amended to read:

Subd. 18a. **Access to medical services.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed ~~$5.50 for breakfast, $6.50 for lunch, or $8 for dinner~~ reimbursement amounts provided in state collective bargaining agreements.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed ~~$50~~ $98 per day unless prior authorized by the local agency.

(c) Regardless of the number of employees that an enrolled health care provider may have, medical assistance covers sign and oral language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient with limited English proficiency or who has a hearing loss and uses interpreting services. Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the enrolled health care provider is listed in the registry or roster established under section 144.058.

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

Sec. 7. Minnesota Statutes 2022, section 256B.0625, subdivision 18h, is amended to read:

Subd. 18h. **Nonemergency medical transportation provisions related to managed care.** (a) The following nonemergency medical transportation (NEMT) subdivisions apply to managed care plans and county-based purchasing plans:

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

(2) subdivision 18; and

(3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

(c) Managed care plans and county-based purchasing plans must provide a fuel adjustment for NEMT rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of

payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

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

Sec. 8. Minnesota Statutes 2022, section 256M.42, is amended to read:

256M.42 ADULT PROTECTION GRANT ALLOCATIONS.

Subdivision 1. **Formula.** (a) The commissioner shall allocate state money appropriated under this section on an annual basis to each county board ~~and tribal government approved by the commissioner to assume county agency duties~~ for adult ~~protective services or as a lead investigative agency~~ protection under section 626.557 ~~on an annual basis in an amount determined~~ and to Tribal Nations that have voluntarily chosen by resolution of Tribal government to participate in vulnerable adult protection programs according to the following formula after the award of the amounts in paragraph (c):

(1) 25 percent must be allocated to the responsible agency on the basis of the number of reports of suspected vulnerable adult maltreatment under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner; and

(2) 75 percent must be allocated to the responsible agency on the basis of the number of screened-in reports for adult protective services or vulnerable adult maltreatment investigations under sections 626.557 and 626.5572, ~~when the county or tribe is responsible~~ as determined by the most recent data of the commissioner.

(b) ~~The commissioner is precluded from changing the formula under this subdivision or recommending a change to the legislature without public review and input.~~ Notwithstanding this subdivision, no county must be awarded less than a minimum allocation established by the commissioner.

(c) To receive money under this subdivision, a participating Tribal Nation must apply to the commissioner. Of the amount appropriated for purposes of this section, the commissioner must award $100,000 to each federally recognized Tribal Nation with a Tribal resolution establishing a vulnerable adult protection program. Money received by a Tribal Nation under this section must be used for its vulnerable adult protection program.

Subd. 2. **Payment.** The commissioner shall make allocations for the state fiscal year starting July 1, ~~2019~~ 2023, and to each county board or tribal government on or before

October 10, ~~2019~~ 2023. The commissioner shall make allocations under subdivision 1 to each county board or tribal government each year thereafter on or before July 10.

Subd. 3. ~~**Prohibition on supplanting existing money**~~ **Purpose of expenditures.** Money received under this section must be used for staffing for protection of vulnerable adults or to expand adult protective services for adults referred by the common entry point for adult protective services. ~~Money must not be used to supplant current county or tribe expenditures for these purposes.~~

Subd. 4. **Required expenditures.** State funds must be used to expand, not supplant, the base of county expenditures for adult protection programs, service interventions, or multidisciplinary teams.

Subd. 5. **County performance on adult protection measures.** The commissioner must set vulnerable adult protection measures and standards for money received under this section. The standards must include but not be limited to a target percentage of adults referred who are accepted by the county for protective services and goals for reducing disparities in service outcomes for adults referred to counties for protective services under section 626.557. The commissioner must require an underperforming county to demonstrate that the county designated money allocated under this section for the purpose required and implemented a reasonable strategy to improve adult protection performance, including the provision of a performance improvement plan and additional remedies identified by the commissioner. The commissioner may redirect up to 20 percent of a county's money under this section toward the performance improvement plan.

Subd. 6. **American Indian adult protection.** Tribal Nations shall establish vulnerable adult protection measures and standards and report annually to the commissioner on these outcomes and the number of adults served.

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

Sec. 9. Minnesota Statutes 2022, section 256R.17, subdivision 2, is amended to read:

Subd. 2. **Case mix indices.** (a) The commissioner shall assign a case mix index to each case mix classification ~~based on the Centers for Medicare and Medicaid Services staff time measurement study~~ as determined by the commissioner of health under section 144.0724.

(b) An index maximization approach shall be used to classify residents. "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

ARTICLE 3
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 1a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM criteria" has the meaning provided in section 254B.01, subdivision 2a.

Sec. 2. Minnesota Statutes 2022, section 245G.01, is amended by adding a subdivision to read:

Subd. 20c. **Protective factors.** "Protective factors" means the actions or efforts a person can take to reduce the negative impact of certain issues, such as substance use disorders, mental health disorders, and risk of suicide. Protective factors include connecting to positive supports in the community, a good diet, exercise, attending counseling or 12-step groups, and taking medications.

Sec. 3. Minnesota Statutes 2022, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** ~~(a)~~ A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within ~~three~~ five calendar days from the day of service initiation for a residential program or ~~within three calendar days on which a treatment session has been provided of the day of service initiation for a client~~ by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~The comprehensive assessment must include sufficient information to complete the assessment summary according to subdivision 2 and the individual treatment plan according to section 245G.06. The comprehensive assessment~~

~~must include information about the client's needs that relate to substance use and personal strengths that support recovery, including:~~

~~(1) age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;~~

~~(2) a description of the circumstances on the day of service initiation;~~

~~(3) a list of previous attempts at treatment for substance misuse or substance use disorder, compulsive gambling, or mental illness;~~

~~(4) a list of substance use history including amounts and types of substances used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each substance used within the previous 30 days, the information must include the date of the most recent use and address the absence or presence of previous withdrawal symptoms;~~

~~(5) specific problem behaviors exhibited by the client when under the influence of substances;~~

~~(6) the client's desire for family involvement in the treatment program, family history of substance use and misuse, history or presence of physical or sexual abuse, and level of family support;~~

~~(7) physical and medical concerns or diagnoses, current medical treatment needed or being received related to the diagnoses, and whether the concerns need to be referred to an appropriate health care professional;~~

~~(8) mental health history, including symptoms and the effect on the client's ability to function; current mental health treatment; and psychotropic medication needed to maintain stability. The assessment must utilize screening tools approved by the commissioner pursuant to section 245.4863 to identify whether the client screens positive for co-occurring disorders;~~

~~(9) arrests and legal interventions related to substance use;~~

~~(10) a description of how the client's use affected the client's ability to function appropriately in work and educational settings;~~

~~(11) ability to understand written treatment materials, including rules and the client's rights;~~

~~(12) a description of any risk-taking behavior, including behavior that puts the client at risk of exposure to blood-borne or sexually transmitted diseases;~~

~~(13) social network in relation to expected support for recovery;~~

~~(14) leisure time activities that are associated with substance use;~~

~~(15) whether the client is pregnant and, if so, the health of the unborn child and the client's current involvement in prenatal care;~~

~~(16) whether the client recognizes needs related to substance use and is willing to follow treatment recommendations; and~~

~~(17) information from a collateral contact may be included, but is not required.~~

~~(b) If the client is identified as having opioid use disorder or seeking treatment for opioid use disorder, the program must provide educational information to the client concerning:~~

~~(1) risks for opioid use disorder and dependence;~~

~~(2) treatment options, including the use of a medication for opioid use disorder;~~

~~(3) the risk of and recognizing opioid overdose; and~~

~~(4) the use, availability, and administration of naloxone to respond to opioid overdose.~~

~~(c) The commissioner shall develop educational materials that are supported by research and updated periodically. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.~~

~~(d) If the comprehensive assessment is completed to authorize treatment service for the client, at the earliest opportunity during the assessment interview the assessor shall determine if:~~

~~(1) the client is in severe withdrawal and likely to be a danger to self or others;~~

~~(2) the client has severe medical problems that require immediate attention; or~~

~~(3) the client has severe emotional or behavioral symptoms that place the client or others at risk of harm.~~

~~If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the assessment interview and follow the procedures in the program's medical services plan under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The assessment interview may resume when the condition is resolved.~~ An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

Sec. 4. Minnesota Statutes 2022, section 245G.05, is amended by adding a subdivision to read:

Subd. 3. **Comprehensive assessment requirements.** (a) A comprehensive assessment must meet the requirements under section 245I.10, subdivision 6, paragraphs (b) and (c). It must include:

(1) a diagnosis of a substance use disorder or a finding that the client does not meet the criteria for a substance use disorder;

(2) a determination of whether the individual screens positive for co-occurring mental health disorders using a screening tool approved by the commissioner pursuant to section 245.4863; and

(3) a recommendation for the ASAM level of care; for programs receiving payment under chapter 254B, the ASAM level of care must be identified in section 254B.19, subdivision 1.

(b) If the individual is assessed for opioid use disorder, the program must provide educational material to the client within 24 hours of service initiation on:

(1) risks for opioid use disorder and dependence;

(2) treatment options, including the use of a medication for opioid use disorder;

(3) the risk of and recognizing opioid overdose; and

(4) the use, availability, and administration of naloxone to respond to opioid overdose.

If the client is identified as having opioid use disorder at a later point, the education must be provided at that point. The license holder must use the educational materials that are approved by the commissioner to comply with this requirement.

Sec. 5. Minnesota Statutes 2022, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. For the purposes of these time frames, the day services are initiated is excluded when calculating the number of days. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of

the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Sec. 6. Minnesota Statutes 2022, section 245G.06, is amended by adding a subdivision to read:

Subd. 1a. **Individual treatment plan contents and process.** (a) After completing an individual's comprehensive assessment, the license holder must complete an individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's comprehensive assessment;

(2) use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's individual treatment services, assessments, and treatment planning;

(3) identify the client's treatment goals;

(4) identify the number of hours of skilled treatment services as defined in section 254B.01 the program plans to provide to the client each week or, if services will be provided less frequently than weekly, the number of hours of treatment services the program plans to provide to the client each month;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family or other natural supports in the client's treatment planning;

(6) identify resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(7) identify maintenance strategy goals and methods designed to address relapse prevention and to strengthen the client's protective factors.

Sec. 7. Minnesota Statutes 2022, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Treatment plan review.** A treatment plan review must be ~~entered in a client's file weekly or after each treatment service, whichever is less frequent,~~ completed by the alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review ~~and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c)~~. The review must:

(1) ~~address each goal in the~~ document client goals addressed since the last treatment plan review and whether the identified methods ~~to address the goals are~~ continue to be effective;

(2) ~~include~~ document monitoring of any physical and mental health problems and include toxicology results for alcohol and substance use, when available;

(3) document the participation of others involved in the individual's treatment planning, including when services are offered to the client's family or significant others;

(4) if changes to the treatment plan are determined to be necessary, document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; ~~and~~

(5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65~~.~~; and

(6) document any referrals made since the previous treatment plan review.

Sec. 8. 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 a treatment plan review is completed, meets the requirements of subdivision 3, and is entered in each client's file by the alcohol and drug counselor responsible for the client's treatment plan according the frequencies in this subdivision.

(b) For a client in a residential program, a treatment plan review must be completed and entered once every 14 days.

(c) For a client in a nonresidential program, a treatment plan review must be completed and entered once every 14 days unless the treatment plan clearly indicates services will be provided to the client less frequently, according to paragraphs (d) and (e).

(d) For clients in a nonresidential program with a treatment plan that clearly indicates less than 20 hours of skilled treatment services will be provided to the client each week or less frequently than weekly, a treatment plan review must be completed and entered once every 30 days.

(e) For clients in a nonresidential program with a treatment plan that clearly indicates less than 5 hours of skilled treatment services will be provided to the client each month or less frequently than monthly, a treatment plan review must be completed and entered once every 90 days.

(f) Notwithstanding this subdivision, opioid treatment programs licensed according to section 245G.22 must complete treatment plan reviews according to the frequencies in section 245G.22, subdivision 15, paragraph (c), clause (3).

Sec. 9. Minnesota Statutes 2022, section 245G.07, subdivision 2, is amended to read:

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services provided one-to-one by an individual in recovery qualified according to section ~~245G.11, subdivision 8~~ 245I.04, subdivision 18. Peer support services include education; advocacy; mentoring through self-disclosure of personal recovery experiences; attending recovery and other support groups with a client; accompanying the client to appointments that support recovery; assistance accessing resources to obtain housing, employment, education, and advocacy services; and nonclinical recovery support to assist the transition from treatment into the recovery community.

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.

Sec. 10. Minnesota Statutes 2022, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must ~~offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary~~ meet the requirements in section 245G.07, subdivision 1, paragraph (a), and must document each time the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service was provided, the license holder must ensure that the staff member who provided the treatment service documents in the client record the date, type, and amount of the treatment service and the client's response to the treatment service within seven days of providing the treatment service.

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and

(3) for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews ~~in the six dimensions~~ at least once monthly or, when clinical need warrants, more frequently.

Sec. 11. Minnesota Statutes 2022, section 245I.04, subdivision 10, is amended to read:

Subd. 10. **Mental health certified peer specialist qualifications.** A mental health certified peer specialist must:

(1) have been diagnosed with a mental illness;

(2) be a current or former mental health services client; and

(3) ~~have a valid certification as a mental health certified peer specialist under section 256B.0615~~ hold a current credential from the Minnesota Certification Board that demonstrates skills and training in ethics and boundaries, advocacy, mentoring and education, and mental health recovery and wellness support.

Sec. 12. Minnesota Statutes 2022, section 245I.04, is amended by adding a subdivision to read:

Subd. 18. **Peer recovery qualifications.** (a) A recovery peer must:

(1) have a minimum of one year in recovery from substance use disorder; and

(2) 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 that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support.

(b) A recovery peer who receives a credential from a Tribal Nation when providing peer recovery support services in a tribally licensed program satisfies the requirement in paragraph (a), clause (2).

Sec. 13. Minnesota Statutes 2022, section 245I.04, is amended by adding a subdivision to read:

Subd. 19. **Peer recovery scope of practice.** A recovery peer, under the supervision of an alcohol and drug counselor, must:

(1) provide individualized peer support to each client;

(2) promote a client's recovery goals, self-sufficiency, self-advocacy, and development of natural supports; and

(3) support a client's maintenance of skills that the client has learned from other services.

Sec. 14. Minnesota Statutes 2022, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, specifically withdrawal, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment; ~~and~~

(10) cultural influences on the client.; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is five years of age or younger, an assessor must administer the Early Childhood Service Intensity Instrument (ECSII) to the client and include the results in the client's assessment.

(4) When completing a standard diagnostic assessment of a client who is six to 17 years of age, an assessor must administer the Child and Adolescent Service Intensity Instrument (CASII) to the client and include the results in the client's assessment.

(5) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. The assessor must make referrals for the client as to services required by law.

Sec. 15. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 2a. **American Society of Addiction Medicine criteria or ASAM criteria.** "American Society of Addiction Medicine criteria" or "ASAM" means the clinical guidelines for purposes of the assessment, treatment, placement, and transfer or discharge of individuals with substance use disorders. The ASAM criteria are contained in the current

edition of the *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*.

Sec. 16. Minnesota Statutes 2022, section 254B.01, subdivision 8, is amended to read:

Subd. 8. **Recovery community organization.** "Recovery community organization" means an independent, nonprofit organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from ~~alcohol and other drug addiction~~ substance use disorder. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

Sec. 17. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 9. **Skilled treatment services.** "Skilled treatment services" has the meaning given for the "treatment services" described in section 245G.07, subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Sec. 18. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 10. **Sober home.** Sober home is a cooperative living residence, a room and board residence, an apartment, or any other living accommodation that:

(1) provides temporary housing to persons with a substance use disorder;

(2) stipulates residents must abstain from using alcohol or other illicit substances not prescribed by a physician and meet other requirements as a condition of living in the home;

(3) charges a fee for living there;

(4) does not provide counseling or treatment services to residents; and

(5) promotes sustained recovery from substance use disorders.

Sec. 19. Minnesota Statutes 2022, section 254B.01, is amended by adding a subdivision to read:

Subd. 11. **Comprehensive assessment.** "Comprehensive assessment" means a person-centered, trauma-informed assessment that:

(1) is completed for a substance use disorder diagnosis, treatment planning, and determination of client eligibility for substance use disorder treatment services;

(2) meets the requirements in section 245G.05; and

(3) is completed by an alcohol and drug counselor qualified according to section 245G.11, subdivision 5.

Sec. 20. Minnesota Statutes 2022, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245I.04, subdivision 18.

(d) A recovery community organization that meets ~~certification~~ the requirements ~~identified by the commissioner~~ of clauses (1) to (10) and meets membership or accreditation requirements of the Association of Recovery Community Organizations, the Council on Accreditation of Peer Recovery Support Services, or a Minnesota statewide recovery

community organization identified by the commissioner is an eligible vendor of peer support services. Eligible vendors under this paragraph must be:

(1) nonprofit organizations;

(2) led and governed by the recovery community with more than 50 percent of the board of directors or advisory boards self-identifying as people in personal recovery from their own substance use disorders;

(3) primarily focused on recovery from substance use disorders, with missions and visions that support this primary focus;

(4) grassroots and reflective of and engaged with the community served;

(5) accountable to the recovery community through processes that promote involvement, engagement, and consultation of people in recovery and their families, friends, and recovery allies;

(6) providers of nonclinical, peer recovery support services, including but not limited to recovery support groups, recovery coaching, telephone recovery support, skill-building groups, and harm-reduction activities;

(7) supportive, allowing for opportunities for all paths toward recovery and refraining from excluding anyone based on their chosen path, which may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) purposeful in meeting the diverse needs of Black, Indigenous, and people of color communities, including board and staff development activities, organizational practices, service offerings, advocacy efforts, and culturally informed outreach and service plans;

(9) stewards of recovery-friendly language that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma; and

(10) maintaining an employee and volunteer code of ethics and easily accessible grievance procedures either posted in physical spaces, on websites, or on program policies or forms.

(e) A recovery community organization that is aggrieved by an accreditation or membership determination and believes it meets the requirements under section 254B.05, subdivision 1, paragraph (d), clauses (1) to (10), may appeal under section 256.045, subdivision 3, clause (15), for reconsideration as an eligible vendor.

~~(e)~~ (f) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the

commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

Sec. 21. Minnesota Statutes 2022, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider requirements.** (a) ~~Effective January 1, 2000,~~ Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(d) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

~~(d)~~ (e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

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

Sec. 22. Minnesota Statutes 2022, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) ~~outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;~~ those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided by the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5);

(vi) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6); and

(vii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7);

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) ~~care~~ treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) ~~on July 1, 2019, or upon federal approval, whichever is later,~~ withdrawal management services provided according to chapter 245F;

(6) substance use disorder treatment services with medications for opioid use disorder ~~that are~~ provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

~~(7) substance use disorder treatment with medications for opioid use disorder plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~

~~(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;~~

~~(9)~~ (7) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

~~(10)~~ (8) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

~~(11) high-intensity residential treatment~~ (9) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide ~~30 hours of clinical services each week~~ ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and is provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

~~(12)~~ (10) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and substance use disorder problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals under section 245I.04, subdivision 2, or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and mental health professional under section 245I.04, subdivision 2, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

Sec. 23. **[254B.17] SUBSTANCE USE DISORDER INFRASTRUCTURE AND CAPACITY-BUILDING GRANTS.**

Subdivision 1. **Culturally responsive recovery community grants.** The commissioner must establish start-up and capacity-building grants for prospective or new recovery

community organizations serving or intending to serve culturally specific or population-specific recovery communities. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring and retaining staff;

(2) staff training, purchasing office equipment and supplies;

(3) purchasing software and website services;

(4) costs associated with establishing nonprofit status;

(5) rental and lease costs and community outreach; and

(6) education and recovery events.

Subd. 2. **Withdrawal management start-up and capacity-building grants.** The commissioner must establish start-up and capacity-building grants for prospective or new withdrawal management programs that will meet medically monitored or clinically monitored levels of care. Grants may be used for expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; and

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements.

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

Sec. 24. **[254B.18] SOBER HOMES.**

Subdivision 1. **Requirements.** All sober homes must comply with applicable state laws and regulations and local ordinances related to maximum occupancy, fire safety, and sanitation. All sober homes must register with the Department of Human Services. In addition, all sober homes must:

(1) maintain a supply of naloxone in the home;

(2) have trained staff that can administer naloxone;

(3) have written policies regarding access to all prescribed medications;

(4) have written policies regarding evictions;

(5) have staff training and policies regarding co-occurring mental illnesses;

(6) not prohibit prescribed medications taken as directed by a licensed prescriber, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder as well as other medications with FDA-approved indications for the treatment of co-occurring disorders; and

(7) return all property and medications to a person discharged from the home and retain the items for a minimum of 60 days if the person did not collect them upon discharge. The owner must make every effort to contact persons listed as emergency contacts so that the items are returned.

Subd. 2. **Certification.** (a) The commissioner shall establish a certification program for sober homes. The certification is mandatory for sober homes receiving any federal, state, or local funding. The certification requirements must include:

(1) health and safety standards, including separate sleeping and bathroom facilities for people who identify as men and people who identify as women, written policies on how to accommodate residents who do not identify as a man or woman, and verification that the home meets fire and sanitation ordinances;

(2) intake admission procedures, including names and contact information in case of an emergency or upon discharge and notification of a family member or other emergency contact designated by the resident under certain circumstances, including but not limited to death due to an overdose;

(3) an assessment of potential resident needs and appropriateness of the residence to meet these needs;

(4) a resident bill of rights, including a right to a refund if discharged;

(5) policies to address mental health and health emergencies to prevent a person from hurting themselves or others, including contact information for emergency resources in the community;

(6) policies on staff qualifications and prohibition against fraternization;

(7) drug-testing procedures and requirements;

(8) policies to mitigate medication misuse, including policies for:

(i) securing medication;

(ii) house staff providing medication at specified times to residents;

(iii) medication counts with staff and residents;

(iv) storing and providing prescribed medications and documenting when a person accesses their prescribed medications; and

(v) ensuring that medications cannot be accessed by other residents;

(9) a policy on medications for opioid use disorder;

(10) having naloxone on site and in a conspicuous location;

(11) prohibiting charging exorbitant fees over and above standard costs for lab tests;

(12) discharge procedures, including involuntary discharge procedures that ensure at least a 24-hours notice prior to filing an eviction action. The notice must include why the resident is being involuntarily discharged and a warning that an eviction action may become public as soon as it is filed, making finding future housing more difficult;

(13) policy on referrals to substance use disorder services, mental health services, peer support services, and support groups;

(14) training for staff on naloxone, mental health crises, de-escalation, person-centered planning, creating a crisis plan, and becoming a culturally informed and responsive sober home;

(15) fee schedule and refund policy;

(16) copies of all forms provided to residents;

(17) rules for residents;

(18) background checks of staff and administrators;

(19) policies that promote recovery by requiring resident participation in treatment, self-help groups or other recovery supports; and

(20) policies requiring abstinence from alcohol and illicit drugs.

(b) Certifications must be renewed every three years.

Subd. 3. **Registry.** The commissioner shall create a registry containing a listing of sober homes that have met the certification requirements. The registry must include each sober home city and zip code, maximum resident capacity, and whether the setting serves a specific population based on race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Subd. 4. **Bill of rights.** An individual living in a sober home has the right to:

(1) access to an environment that supports recovery;

(2) access to an environment that is safe and free from alcohol and other illicit substances;

(3) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act;

(4) be treated with dignity and respect and to have personal property treated with respect;

(5) have personal, financial, and medical information kept private and to be advised of the program's policies and procedures regarding disclosure of such information;

(6) access, while living in the residence, to other community-based support services as needed;

(7) be referred to appropriate services upon leaving the residence if necessary;

(8) retain personal property that does not jeopardize safety or health;

(9) assert these rights personally or have them asserted by the individual's representative or by anyone on behalf of the individual without retaliation;

(10) be provided with the name, address, and telephone number of the ombudsman for mental health, substance use disorder, and developmental disabilities and information about the right to file a complaint;

(11) be fully informed of these rights and responsibilities, as well as to program policies and procedures; and

(12) not be required to perform services for the residence that are not included in the usual expectations for all residents.

Subd. 5. **Private right of action.** In addition to pursuing other remedies, an individual may bring an action to recover damages caused by a violation of this section. The court shall award a resident who prevails in an action under this section double damages, costs, disbursements, reasonable attorney fees, and any equitable relief the court deems appropriate.

Sec. 25. **[254B.19] AMERICAN SOCIETY OF ADDICTION MEDICINE STANDARDS OF CARE.**

Subdivision 1. **Level of care requirements.** For each client assigned an ASAM level of care, eligible vendors must implement the standards set by the ASAM for the respective level of care. Additionally, vendors must meet the following requirements.

(1) For ASAM level 0.5 early intervention targeting individuals who are at risk of developing a substance-related problem but may not have a diagnosed substance use disorder, early intervention services may include individual or group counseling, treatment coordination, peer recovery support, screening brief intervention, and referral to treatment provided according to section 254A.03, subdivision 3, paragraph (c).

(2) For ASAM level 1.0 outpatient clients, adults must receive up to eight hours per week of skilled treatment services and adolescents must receive up to five hours per week. Services must be licensed according to section 245G.20 and meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week.

(3) For ASAM level 2.1 intensive outpatient clients, adults must receive nine to 19 hours per week of skilled treatment services and adolescents must receive six or more hours per week. Vendors must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Peer recovery and treatment coordination may be provided beyond the hourly skilled treatment service hours allowable per week. If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(4) For ASAM level 2.5 partial hospitalization clients, adults must receive 20 hours or more of skilled treatment services. Services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Level 2.5 is for clients who need daily monitoring in a structured setting as directed by the individual treatment plan and in accordance with the limitations in section 254B.05, subdivision 5, paragraph (h). If clinically indicated on the client's treatment plan, this service may be provided in conjunction with room and board according to section 254B.05, subdivision 1a.

(5) For ASAM level 3.1 clinically managed low-intensity residential clients, programs must provide at least 5 hours of skilled treatment services per week according to each client's specific treatment schedule as directed by the individual treatment plan. Programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759.

(6) For ASAM level 3.3 clinically managed population-specific high-intensity residential clients, programs must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage. Programs must be enrolled as a disability responsive program as described in section 254B.01, subdivision 4b, and must specialize in serving persons with a traumatic brain injury or a cognitive impairment so significant, and the resulting level of impairment so great, that outpatient or other levels of residential care would not be feasible or effective. Programs must provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(7) For ASAM level 3.5 clinically managed high-intensity residential clients, services must be licensed according to section 245G.20 and must meet requirements under section 256B.0759. Programs must have 24-hour-a-day staffing coverage and provide, at minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule as directed by the individual treatment plan.

(8) For ASAM level withdrawal management 3.2 clinically managed clients, withdrawal management must be provided according to chapter 245F.

(9) For ASAM level withdrawal management 3.7 medically monitored clients, withdrawal management must be provided according to chapter 245F.

Subd. 2. **Patient referral arrangement agreement.** The license holder must maintain documentation of a formal patient referral arrangement agreement for each of the following levels of care not provided by the license holder:

(1) level 1.0 outpatient;

(2) level 2.1 intensive outpatient;

(3) level 2.5 partial hospitalization;

(4) level 3.1 clinically managed low-intensity residential;

(5) level 3.3 clinically managed population-specific high-intensity residential;

(6) level 3.5 clinically managed high-intensity residential;

(7) level withdrawal management 3.2 clinically managed residential withdrawal management; and

(8) level withdrawal management 3.7 medically monitored inpatient withdrawal management.

Subd. 3. **Evidence-based practices.** ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have documentation of the evidence-based practices being utilized that include at least three of the following:

(1) 12-step facilitation;

(2) brief cognitive behavioral therapy;

(3) motivational interviewing; and

(4) contingency management.

Subd. 4. **Program outreach plan.** Eligible vendors providing services under ASAM levels of care referenced in subdivision 1, clauses (2) to (7), must have a program outreach plan. The treatment director must document a review and update the plan annually. The program outreach plan must include treatment coordination strategies and processes to ensure seamless transitions across the continuum of care. The plan must include how the provider will:

(1) increase the awareness of early intervention treatment services, including but not limited to the services defined in section 254A.03, subdivision 3, paragraph (c);

(2) coordinate, as necessary, with certified community behavioral health clinics when a license holder is located in a geographic region served by a certified community behavioral health clinic;

(3) establish a referral arrangement agreement with a withdrawal management program licensed under chapter 245F when a license holder is located in a geographic region in which a withdrawal management program is licensed under chapter 245F. If a withdrawal management program licensed under chapter 245F is not geographically accessible, the plan must include how the provider will address the client's need for this level of care;

(4) coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment;

(5) develop and maintain collaboration with local county and Tribal human services agencies; and

(6) collaborate with primary care and mental health settings.

Sec. 26. Minnesota Statutes 2022, section 256.042, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2022, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the grants proposed by the advisory council to be awarded for the upcoming calendar year to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by December 1 of each year, beginning December 1, 2022. This paragraph expires upon the expiration of the advisory council.

(b) The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (h), and subdivision 3a, paragraph (d). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than ten percent of the grant amount may be used by a grantee for administration. The commissioner must award at least 50 percent of grants to projects that include a focus on addressing the opioid crisis in Black and Indigenous communities and communities of color.

Sec. 28. Minnesota Statutes 2022, section 256.045, subdivision 3, is amended to read:

Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

(1) any person applying for, receiving or having received public assistance, medical care, or a program of social services granted by the state agency or a county agency or the federal Food and Nutrition Act whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid;

(2) any patient or relative aggrieved by an order of the commissioner under section 252.27;

(3) a party aggrieved by a ruling of a prepaid health plan;

(4) except as provided under chapter 245C, any individual or facility determined by a lead investigative agency to have maltreated a vulnerable adult under section 626.557 after they have exercised their right to administrative reconsideration under section 626.557;

(5) any person whose claim for foster care payment according to a placement of the child resulting from a child protection assessment under chapter 260E is denied or not acted upon with reasonable promptness, regardless of funding source;

(6) any person to whom a right of appeal according to this section is given by other provision of law;

(7) an applicant aggrieved by an adverse decision to an application for a hardship waiver under section 256B.15;

(8) an applicant aggrieved by an adverse decision to an application or redetermination for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

(9) except as provided under chapter 245A, an individual or facility determined to have maltreated a minor under chapter 260E, after the individual or facility has exercised the right to administrative reconsideration under chapter 260E;

(10) except as provided under chapter 245C, an individual disqualified under sections 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23, on the basis of serious or recurring maltreatment; a preponderance of the evidence that the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section 260E.06, subdivision 1, or 626.557, subdivision 3. Hearings regarding a maltreatment determination under clause (4) or (9) and a disqualification under this clause in which the basis for a disqualification is serious or recurring maltreatment, shall be consolidated into a single fair hearing. In such cases, the scope of review by the human services judge shall include both the maltreatment determination and the disqualification. The failure to exercise the right to an administrative reconsideration shall not be a bar to a hearing under this section if federal law provides an individual the right to a hearing to dispute a finding of maltreatment;

(11) any person with an outstanding debt resulting from receipt of public assistance, medical care, or the federal Food and Nutrition Act who is contesting a setoff claim by the Department of Human Services or a county agency. The scope of the appeal is the validity of the claimant agency's intention to request a setoff of a refund under chapter 270A against the debt;

(12) a person issued a notice of service termination under section 245D.10, subdivision 3a, by a licensed provider of any residential supports or services listed in section 245D.03, subdivision 1, paragraphs (b) and (c), that is not otherwise subject to appeal under subdivision 4a;

(13) an individual disability waiver recipient based on a denial of a request for a rate exception under section 256B.4914; ~~or~~

(14) a person issued a notice of service termination under section 245A.11, subdivision 11, that is not otherwise subject to appeal under subdivision 4a~~.~~; or

(15) a recovery community organization seeking medical assistance vendor eligibility under section 254B.01, subdivision 8, that is aggrieved by a membership or accreditation determination and that believes the organization meets the requirements under section 254B.05, subdivision 1, paragraph (d), clauses (1) to (10). The scope of the review by the human service judge shall be limited to whether the organization meets each of the requirements under section 254B.05, subdivision 1, paragraph (d), clauses (1) to (10).

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, paragraphs (c) to (e), or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of

termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

(g) An applicant or recipient is not entitled to receive social services beyond the services prescribed under chapter 256M or other social services the person is eligible for under state law.

(h) The commissioner may summarily affirm the county or state agency's proposed action without a hearing when the sole issue is an automatic change due to a change in state or federal law.

(i) Unless federal or Minnesota law specifies a different time frame in which to file an appeal, an individual or organization specified in this section may contest the specified action, decision, or final disposition before the state agency by submitting a written request for a hearing to the state agency within 30 days after receiving written notice of the action, decision, or final disposition, or within 90 days of such written notice if the applicant, recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision 13, why the request was not submitted within the 30-day time limit. The individual filing the appeal has the burden of proving good cause by a preponderance of the evidence.

Sec. 29. Minnesota Statutes 2022, section 256.478, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual does not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who meets at least one of the following criteria:

(1) the person otherwise meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota ~~Security Hospital~~ Forensic Mental Health Program, the Child Adolescent Behavioral Health Hospital program, a psychiatric residential treatment facility under section 256B.0941, intensive residential treatment services under section

256B.0622, children's residential services under section 245.4882, or a ~~community behavioral health~~ hospital would be substantially delayed without additional resources available through the transitions to community initiative; or

~~(3) the person is in a community hospital, but alternative community living options would be appropriate for the person, and the person has received approval from the commissioner; or~~

~~(4) (i)~~ (3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) ~~the person~~ expresses a desire to move; and (iii) ~~the person~~ has received approval from the commissioner.

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

Sec. 30. Minnesota Statutes 2022, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, ~~subject to federal approval,~~ if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 31. Minnesota Statutes 2022, section 256B.0615, subdivision 5, is amended to read:

Subd. 5. **Certified peer specialist ~~training and~~ certification.** ~~The commissioner of human services shall develop a training and certification process for certified peer specialists. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.~~ A certified peer specialist is qualified as a mental health peer specialist as defined in section 245I.04 and must hold a current credential from the Minnesota Certification Board.

Sec. 32. Minnesota Statutes 2022, section 256B.0759, subdivision 2, is amended to read:

Subd. 2. **Provider participation.** (a) ~~Outpatient~~ Programs licensed by the Department of Human Services as nonresidential substance use disorder treatment ~~providers may elect to participate in the demonstration project and meet the requirements of subdivision 3. To~~

~~participate, a provider must notify the commissioner of the provider's intent to participate in a format required by the commissioner and enroll as a demonstration project provider~~ programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2025. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(b) Programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(c) Programs licensed by the Department of Human Services as withdrawal management programs according to chapter 245F that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(d) Out-of-state residential substance use disorder treatment programs that receive payment under this chapter must enroll as demonstration project providers and meet the requirements of subdivision 3 by January 1, 2024. Programs that do not meet the requirements of this paragraph are ineligible for payment for services provided under section 256B.0625.

(e) Tribally licensed programs may elect to participate in the demonstration project and meet the requirements of subdivision 3. The Department of Human Services must consult with Tribal nations to discuss participation in the substance use disorder demonstration project.

(f) The commissioner shall allow providers enrolled in the demonstration project before July 1, 2021, to receive applicable rate enhancements authorized under subdivision 4 for all services provided on or after the date of enrollment, except that the commissioner shall allow a provider to receive applicable rate enhancements authorized under subdivision 4 for services provided on or after July 22, 2020, to fee-for-service enrollees, and on or after January 1, 2021, to managed care enrollees, if the provider meets all of the following requirements:

(1) the provider attests that during the time period for which the provider is seeking the rate enhancement, the provider took meaningful steps in their plan approved by the commissioner to meet the demonstration project requirements in subdivision 3; and

(2) the provider submits attestation and evidence, including all information requested by the commissioner, of meeting the requirements of subdivision 3 to the commissioner in a format required by the commissioner.

(g) The commissioner may recoup any rate enhancements paid under paragraph (f) to a provider that does not meet the requirements of subdivision 3 by July 1, 2021.

Sec. 33. **RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT.**

The commissioner of human services must increase the reimbursement rate for adult day treatment by 50 percent over the reimbursement rate in effect as of June 30, 2023.

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

Sec. 34. **ROOM AND BOARD COSTS IN CHILDREN'S RESIDENTIAL FACILITIES.**

The commissioner must update the behavioral health fund room and board rate schedule to include services provided under Minnesota Statutes, section 245.4882, for individuals who do not have a placement under Minnesota Statutes, chapter 260C or 260D. The commissioner must establish room and board rates commensurate with current room and board rates for adolescent programs licensed under Minnesota Statutes, section 245G.18.

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

Sec. 35. **REVISED PAYMENT METHODOLOGY FOR OPIOID TREATMENT PROGRAMS.**

The commissioner must revise the payment methodology for substance use services with medications for opioid use disorder under Minnesota Statutes, section 254B.05, subdivision 5, paragraph (b), clause (6). Payment must occur only if the provider renders the service or services billed on that date of service or, in the case of drugs and drug-related services, within a week as defined by the commissioner. The revised payment methodology must include a weekly bundled rate that includes the costs of drugs, drug administration and observation, drug packaging and preparation, and nursing time. The bundled weekly rate must be based on the Medicare rate. The commissioner must seek all necessary waivers, state plan amendments, and federal authorities required to implement the revised payment methodology.

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

Sec. 36. **STUDY ON MEDICAL ASSISTANCE TRADITIONAL HEALING BEHAVIORAL HEALTH SERVICES IN CORRECTIONAL FACILITIES AND CONTINGENCY MANAGEMENT.**

The commissioner, in consultation with stakeholders, must evaluate the feasibility, potential design, and federal authorities needed to cover traditional healing behavioral health services in correctional facilities and contingency management under the medical assistance program.

Sec. 37. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245G.01, subdivision 20b, as Minnesota Statutes, section 245G.01, subdivision 20d, and make any necessary cross-references.

Sec. 38. **REPEALER.**

Minnesota Statutes 2022, sections 245G.06, subdivision 2; and 245G.11, subdivision 8, are repealed.

ARTICLE 4
DEPARTMENT OF DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2022, section 15.01, is amended to read:

15.01 DEPARTMENTS OF THE STATE.

The following agencies are designated as the departments of the state government: the Department of Administration~~;~~, the Department of Agriculture~~;~~, the Department of Commerce~~;~~, the Department of Corrections~~;~~, the Department of Direct Care and Treatment, the Department of Education~~;~~, the Department of Employment and Economic Development~~;~~, the Department of Health~~;~~, the Department of Human Rights~~;~~, the Department of Human Services, the Department of Information Technology Services~~;~~, the Department of Iron Range Resources and Rehabilitation~~;~~, the Department of Labor and Industry~~;~~, the Department of Management and Budget~~;~~, the Department of Military Affairs~~;~~, the Department of Natural Resources~~;~~, the Department of Public Safety~~; the Department of Human Services;~~, the

Department of Revenue~~;~~, the Department of Transportation~~;~~, the Department of Veterans Affairs~~;~~ and their successor departments.

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

Sec. 2. Minnesota Statutes 2022, section 15.06, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** This section applies to the following departments or agencies: the Departments of Administration, Agriculture, Commerce, Corrections, Direct Care and Treatment, Education, Employment and Economic Development, Health, Human Rights, Human Services, Labor and Industry, Management and Budget, Natural Resources, Public Safety, ~~Human Services,~~ Revenue, Transportation, and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the Office of Commissioner of Iron Range Resources and Rehabilitation; the Department of Information Technology Services; the Bureau of Mediation Services; and their successor departments and agencies. The heads of the foregoing departments or agencies are "commissioners."

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

Sec. 3. Minnesota Statutes 2022, section 43A.08, subdivision 1a, is amended to read:

Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following agencies may designate additional unclassified positions according to this subdivision: the Departments of Administration~~;~~, Agriculture~~;~~, Commerce~~;~~, Corrections~~;~~, Direct Care and Treatment, Education~~;~~, Employment and Economic Development~~;~~, Explore Minnesota Tourism~~;~~, Management and Budget~~;~~, Health~~;~~, Human Rights~~;~~, Human Services, Labor and Industry~~;~~, Natural Resources~~;~~, Public Safety~~;~~, ~~Human Services;~~ Revenue~~;~~, Transportation~~;~~, and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the Department of Information Technology Services; the Offices of the Attorney General, Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the Minnesota Office of Higher Education; the Perpich Center for Arts Education; and the Minnesota Zoological Board.

A position designated by an appointing authority according to this subdivision must meet the following standards and criteria:

(1) the designation of the position would not be contrary to other law relating specifically to that agency;

(2) the person occupying the position would report directly to the agency head or deputy agency head and would be designated as part of the agency head's management team;

(3) the duties of the position would involve significant discretion and substantial involvement in the development, interpretation, and implementation of agency policy;

(4) the duties of the position would not require primarily personnel, accounting, or other technical expertise where continuity in the position would be important;

(5) there would be a need for the person occupying the position to be accountable to, loyal to, and compatible with, the governor and the agency head, the employing statutory board or commission, or the employing constitutional officer;

(6) the position would be at the level of division or bureau director or assistant to the agency head; and

(7) the commissioner has approved the designation as being consistent with the standards and criteria in this subdivision.

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

Sec. 4. **[246C.01] TITLE.**

This chapter may be cited as the "Department of Direct Care & Treatment Act."

Sec. 5. **[246C.02] DEPARTMENT OF DIRECT CARE AND TREATMENT; ESTABLISHMENT.**

(a) The Department of Direct Care and Treatment is created. An executive board shall head the Department of Direct Care and Treatment. The executive board shall develop and maintain direct care and treatment in a manner consistent with applicable law, including chapters 13, 245, 246, 246B, 252, 253, 253B, 253C, 253D, 254A, 254B, and 256. The Department of Direct Care and Treatment shall provide direct care and treatment services in coordination with counties and other vendors. Direct care and treatment services shall include specialized inpatient programs at secure treatment facilities as defined in sections 253B.02, subdivision 18a, and 253D.02, subdivision 13; community preparation services; regional treatment centers; enterprise services; consultative services; aftercare services; community-based services and programs; transition services; nursing home services; and other services consistent with the mission of the Department of Direct Care and Treatment.

(b) "Community preparation services" means specialized inpatient or outpatient services or programs operated outside of a secure environment but administered by a secure treatment facility.

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

Sec. 6. **[246C.03] TRANSITION OF AUTHORITY; DEVELOPMENT OF A BOARD.**

Subdivision 1. **Authority until board is developed and powers defined.** Upon the effective date of this act, the commissioner of human services shall continue to exercise all authorities and responsibilities under chapters 13, 245, 246, 246B, 252, 253, 253B, 253C, 253D, 254A, 254B, and 256, until legislation is effective that develops the Department of Direct Care and Treatment executive board and defines the responsibilities and powers of the Department of Direct Care and Treatment and its executive board.

Subd. 2. **Development of Department of Direct Care and Treatment Board.** (a) The commissioner of human services shall prepare legislation for introduction during the 2024 legislative session, with input from stakeholders the commissioner deems necessary, proposing legislation for the creation and implementation of the Direct Care and Treatment executive board and defining the responsibilities, powers, and function of the Department of Direct Care and Treatment executive board.

(b) The Department of Direct Care and Treatment executive board shall consist of no more than five members, all appointed by the governor.

(c) An executive board member's qualifications must be appropriate for overseeing a complex behavioral health system, such as experience serving on a hospital or non-profit board or working as a licensed health care provider, in an allied health profession, or in health care administration.

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

Sec. 7. **[246C.04] TRANSFER OF DUTIES.**

(a) Section 15.039 applies to the transfer of duties required by this chapter.

(b) The commissioner of administration, with the governor's approval, shall issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties required by section 246C.01. The provision of section 16B.37, subdivision 1, stating that transfers under section 16B.37 may only be to an agency that has existed for at least one year does not apply to transfers to an agency created by this chapter.

(c) The initial salary for the health systems chief executive officer of the Department of Direct Care and Treatment is the same as the salary for the health systems chief executive officer of direct care and treatment at the Department of Human Services immediately before July 1, 2024.

Sec. 8. **[246C.05] SUCCESSOR AND EMPLOYEE PROTECTION CLAUSE.**

(a) Personnel who perform the functions assigned to the commissioner of direct care and treatment in chapters 13, 43A, 245, 246, 246B, 252, 253, 253B, 253D, and 256 and any other applicable chapters or sections of law are transferred to the Department of Direct Care and Treatment effective 30 days after approval of the transfer by the commissioner of direct care and treatment.

(b) All employees of the Department of Human Services transferred to the Department of Direct Care and Treatment will become employees of the Department of Direct Care and Treatment and will cease to be employees of the Department of Human Services, effective 30 days after approval of the transfer by the commissioner of direct care and treatment. Transferred employees must be assigned the same employment status, bargaining unit, and job classification as they had at the time of the transfer. Nothing in this provision prohibits the Department of Direct Care and Treatment from taking any action subsequent to the transfer that is allowed under chapter 43A, a collective bargaining agreement, or compensation plan, or is otherwise permitted by law.

(c) All collective bargaining agreements and compensation plans that cover any employee of the Department of Human Services who is transferred to the Department of Direct Care and Treatment continue in full force and effect with the Department of Direct Care and Treatment.

Sec. 9. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with staff from the House Research Department; House Fiscal Analysis; the Office of Senate Counsel, Research and Fiscal Analysis; and the respective departments shall prepare legislation for introduction in the 2024 legislative session proposing the statutory changes necessary to implement the transfers of duties that this article requires.

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

ARTICLE 5

FORECAST ADJUSTMENTS

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 15, and Laws 2021, First Special Session chapter 7, article 16, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2023" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2023.

		APPROPRIATIONS Available for the Year Ending June 30 2023
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$**	**(944,000)**
Appropriations by Fund		
	2023	
General	(944,000)	
Subd. 2. **Forecasted Programs**		
Behavioral Health Fund		(944,000)

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 6

APPROPRIATIONS

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

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.

"The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

		APPROPRIATIONS	
		Available for the Year	
		Ending June 30	
		2024	2025

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

Subdivision 1. **Total Appropriation**	**$**	**4,429,166,000**	**$**	**4,750,908,000**

Appropriations by Fund

	2024	2025
General	4,423,839,000	4,475,981,000
State Government Special Revenue	865,000	865,000
Lottery Prize	1,896,000	1,896,000
Opiate Epidemic Response	2,566,000	2,166,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Central Office; Operations**

Appropriations by Fund

General	14,805,000	10,574,000
State Government Special Revenue	740,000	740,000

Base level adjustment. The general fund base is $9,031,000 in fiscal year 2026 and $9,214,000 in fiscal year 2027.

Subd. 3. **Central Office; Health Care**

Appropriations by Fund

General	2,505,000	3,032,000

Subd. 4. **Central Office; Continuing Care for Older Adults**

	Appropriations by Fund	
General	46,646,000	46,816,000
State Government Special Revenue	125,000	125,000

(a) **Research on access to long-term care services.** $700,000 in fiscal year 2024 is from the general fund to support an actuarial research study of public and private financing options for long-term services and supports reform to increase access across the state. This is a onetime appropriation.

(b) **Base level adjustment.** The general fund base is $45,376,000 in fiscal year 2026 and $45,232,000 in fiscal year 2027.

Subd. 5. **Central Office; Behavioral Health, Housing, and Deaf and Hard of Hearing Services**

	Appropriations by Fund	
General	1,867,000	1,994,000
Lottery Prize	163,000	163,000
Opioid Epidemic Response	66,000	66,000

(a) $143,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are from the general fund to provide funding for the Minnesota Certification Board to standardize requirements, integrate training, and require the board to certify peer specialists using an integrated mental health and substance use disorder curriculum.

(b) **Base level adjustment.** The general fund base is $1,745,000 in fiscal year 2026 and $1,645,000 in fiscal year 2027.

Subd. 6. **Forecasted Programs; Minnesota Supplemental Aid** 3,664,000 7,565,000

Subd. 7. **Forecasted Programs; Medical Assistance**

Appropriations by Fund

General 3,511,719,000 3,854,899,000

Subd. 8. **Forecasted Programs; Alternative Care** 47,034,000 50,637,000

Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

Subd. 9. **Forecasted Programs; Behavioral Health Fund** 101,440,000 102,733,000

Subd. 10. **Grant Programs; Children and Community Service Grants** -0- 100,000

This appropriation is from the opiate epidemic response fund.

Subd. 11. **Grant Programs; Other Long-Term Care Grants** 24,013,000 24,925,000

(a) **Continuing provider capacity grants.** $8,000,000 for fiscal year 2025 is from the general fund for grants under Minnesota Statutes, section 256.4761.

(b) **Supporting New Americans grants.** $5,000,000 in fiscal year 2024 and $15,000,000 in fiscal year 2025 are from the general fund for grants under Minnesota Statutes, section 256.7462.

Subd. 12. **Grant Programs; Aging and Adult Services Grants** 43,605,000 44,465,000

(a) **Age-friendly community grants.** $0 in fiscal year 2024, $1,000,000 in fiscal year 2025, $1,000,000 in fiscal year 2026, and $1,000,000 in fiscal year 2027 are from the general fund for the continuation of age-friendly community grants originally passed under Laws 2021, First Special Session

chapter 7, article 17, section 8, subdivision 1. This is a onetime appropriation and is available until June 30, 2027.

(b) **Age-friendly technical assistance grants.** $0 in fiscal year 2024, $575,000 in fiscal year 2025, $575,000 in fiscal year 2026, and $575,000 in fiscal year 2027 are from the general fund for the continuation of age-friendly technical assistance grants originally passed under Laws 2021, First Special Session chapter 7, article 17, section 8, subdivision 2. This is a onetime appropriation and is available until June 30, 2027.

(c) **Base level adjustment.** The general fund base is $45,201,000 in fiscal year 2026 and $45,327,000 in fiscal year 2027.

Subd. 13. **Grant Programs; Disabilities Grants**	95,824,000	32,460,000

(a) **Direct support connect.** $250,000 in fiscal year 2026 is from the general fund to expand direct support connect to diversify and improve Disability Hub data outreach and evaluation. This is a onetime base adjustment.

(b) **Transition grants for small customized living providers.** $650,000 in fiscal year 2024 and $650,000 in fiscal year 2025 are from the general fund for grants to assist transitions of small customized living providers as defined under Minnesota Statutes, section 245D.24. This is a onetime appropriation available through June 30, 2025.

(c) **Lead agency capacity building grants.** $500,000 in fiscal year 2024 and $2,500,000 in fiscal year 2025 are from the general fund

for grants to assist organizations, counties, and Tribes to build capacity for employment opportunities for people with disabilities.

(d) **Employment and technical assistance center grants.** $450,000 in fiscal year 2024 and $1,800,000 in fiscal year 2025 are from the general fund for employment and technical assistance grants to assist organizations and employers in promoting a more inclusive workplace for people with disabilities.

(e) **Case management training grants.** $37,000 in fiscal year 2024, $123,000 in fiscal year 2025, $45,000 in fiscal year 2026, and $45,000 in fiscal year 2027 are from the general fund for grants to provide case management training to organizations and employers to support the state's disability employment supports system.

(f) **Electronic visit verification stipends.** $6,440,000 in fiscal year 2024 is for onetime stipends of $200 to bargaining members to offset the potential costs related to people using individual devices to access the electronic visit verification system. $5,600,000 of the appropriation is for stipends and the remaining 15 percent is for administration of these stipends. This is a onetime appropriation.

(g) **Self-directed collective bargaining agreement; temporary rate increase memorandum of understanding.** $1,610,000 in fiscal year 2024 is for onetime stipends for individual providers covered by the SEIU collective bargaining agreement based on the memorandum of understanding related to the temporary rate increase in effect between

December 1, 2020, and February 7, 2021. $1,400,000 of the appropriation is for stipends and the remaining 15 percent is for administration of the stipends. This is a onetime appropriation.

(h) **Self-directed collective bargaining agreement; retention bonuses.** $50,102,000 in fiscal year 2024 is for onetime retention bonuses covered by the SEIU collective bargaining agreement. $50,000,000 of the appropriation is for retention bonuses and the remaining 15 percent is for administration of the bonuses. This is a onetime appropriation.

(i) **Training stipends.** $2,068,000 in fiscal year 2024 and $68,000 in fiscal year 2025 are for onetime stipends of $500 for collective bargaining unit members who complete designated, voluntary trainings made available through or recommended by the State Provider Cooperation Committee. $2,000,000 of the appropriation is for stipends and the remaining amount in both fiscal year 2024 and fiscal 2025 is for the administration of stipends. This is a onetime appropriation.

(j) **Orientation program and establishment of Taft-Hartley trust fund.** $3,193,000 in fiscal year 2024 and $2,225,000 in fiscal year 2025 are for onetime $100 payments for collective bargaining unit members who complete orientation requirements. $1,500,000 in fiscal year 2024 and $1,500,000 in fiscal year 2025 are for the onetime payments, while $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are for orientation related costs. $1,000,000 in fiscal year 2024

establishes the Taft-Hartley Trust Fund. The remaining amount is for administration of the orientation program and payments. This is a onetime appropriation.

(k) **Base level adjustment.** The general fund base is $29,605,000 in fiscal year 2026 and $29,030,000 in fiscal year 2027.

Subd. 14. **Grant Programs; Adult Mental Health Grants**

	Appropriations by Fund	
General	1,000,000	1,000,000
Opiate Epidemic Response	2,000,000	-0-

Subd. 15. **Grant Programs; Chemical Dependency Treatment Support Grants**

	Appropriations by Fund	
General	5,747,000	6,247,000
Lottery Prize	1,733,000	1,733,000
Opiate Epidemic Response	500,000	2,000,000

(a) $2,000,000 in fiscal year 2025 is from the opioid epidemic response fund for traditional healing grants.

(b) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for start-up grant funding for culturally specific recovery community organizations to build capacity and improve access to substance use disorder treatment for Black, Indigenous, and People of Color to access culturally specific peer services.

(c) $1,000,000 in fiscal year 2024 and $1,000,000 in fiscal year 2025 are from the general fund for grants to expand the peer workforce through training and development

of peers providing services to people impacted by mental health and substance use disorders.

Subd. 16. **Direct Care and Treatment - Transfer Authority**

(a) Money appropriated for budget activities under subdivisions 17 to 21 may be transferred between budget activities and between years of the biennium with the approval of the commissioner of management and budget.

(b) Ending balances in obsolete accounts in the special revenue fund and other dedicated accounts within direct care and treatment may be transferred to other dedicated and gift fund accounts within direct care and treatment for client use and other client activities, with approval of the commissioner of management and budget. These transactions shall be completed by June 30, 2023.

Subd. 17. **Direct Care and Treatment - Mental Health and Substance Abuse**	175,350,000	183,215,000

(a) The commissioner responsible for operations of direct care and treatment services, with the approval of the commissioner of management and budget, may transfer any balance in the enterprise fund established for the community addiction recovery enterprise program to the general fund appropriation within this subdivision. Any balance remaining after June 30, 2025, cancels to the general fund.

(b) During fiscal year 2024 and fiscal year 2025 balances in the chemical dependency services fund may be transferred to the general fund appropriation within this subdivision with the approval of the commissioner of

management and budget. Balances remaining in the Department of Human Services chemical dependency services fund on July 1, 2026, shall cancel to the state's general fund.

Subd. 18. **Direct Care and Treatment - Community-Based Services**	15,462,000	15,776,000
Subd. 19. **Direct Care and Treatment - Forensic Services**	141,020,000	148,513,000
Subd. 20. **Direct Care and Treatment - Sex Offender Program**	115,920,000	121,726,000
Subd. 21. **Direct Care and Treatment - Operations**	74,218,000	89,404,000

The general fund base is $82,056,000 in fiscal year 2026 and $82,976,000 in fiscal year 2027.

Sec. 3. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2025, within fiscal years among the MFIP; general assistance; medical assistance; MinnesotaCare; MFIP child care assistance under Minnesota Statutes, section 119B.05; Minnesota supplemental aid program; group residential housing program; the entitlement portion of Northstar Care for Children under Minnesota Statutes, chapter 256N; and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner considers necessary, with the advance approval of the commissioner of management and budget. The commissioners shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

245G.06 INDIVIDUAL TREATMENT PLAN.

Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue identified in the assessment summary, prioritized according to the client's needs and focus, and must include:

(1) specific goals and methods to address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

(2) resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(3) goals the client must reach to complete treatment and terminate services.

245G.11 STAFF QUALIFICATIONS.

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.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 6b. **Family residential services; component values and calculation of payment rates.** (a) Component values for family residential services are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 3.3 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence factor: 1.7 percent.

(b) Payments for family residential services must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs provided on site or through monitoring technology;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the product of the supervisory span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared and individual direct staffing hours provided through monitoring technology, by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8);

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

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

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

256S.19 MONTHLY CASE MIX BUDGET CAPS; NURSING FACILITY RESIDENTS.

Subd. 4. **Calculation of monthly conversion budget cap with consumer-directed community supports.** For the elderly waiver monthly conversion budget cap for the cost of elderly waiver services with consumer-directed community supports, the nursing facility case mix adjusted total payment rate used under subdivision 3 to calculate the monthly conversion budget cap for elderly waiver services without consumer-directed community supports must be reduced by a percentage equal to the percentage difference between the consumer-directed community supports budget limit that would be assigned according to the elderly waiver plan and the corresponding monthly case mix budget cap under this chapter, but not to exceed 50 percent.